UNIVERSITY OF ALBERTA

RECOVERED BULIMICS - A SUBSTANTIVE THEORY OF RECOVERY FOR BULIMIA NERVOSA

BY

SHEILA O'BYRNE

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY.

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL, 1990

National Library of Canada
Bibliothèque nationale du Canada

Canadian Theses Service
Service des thèses canadiennes

Ottawa, Canada
K1A 0N4

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-64813-9

UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: SHEILA O'BYRNE

TITLE OF THESIS: RECOVERED BULIMICS: A SUBSTANTIVE THEORY OF RECOVERY FOR BULIMIA NERVOSA

DEGREE: DOCTOR OF PHILOSOPHY

YEAR THIS DEGREE GRANTED: 1990

PERMISSION IS HEREBY GRANTED TO THE UNIVERSITY OF ALBERTA LIBRARY TO REPRODUCE SINGLE COPIES OF THIS THESIS AND TO LEND OR SELL SUCH COPIES FOR PRIVATE, SCHOLARLY OR SCIENTIFIC RESEARCH PURPOSES ONLY.

THE AUTHOR RESERVES OTHER PUBLICATION RIGHTS, AND NEITHER THE THESIS NOR EXTENSIVE EXTRACTS FROM IT MAY BE PRINTED OR OTHERWISE REPRODUCED WITHOUT THE AUTHOR'S WRITTEN PERMISSION.

Sheila O'Byrne

#120 - 50 Songhees Rd.
Victoria, B.C.
V9A 7J4

Date: Sept 18/90

7

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

THE UNDERSIGNED CERTIFY THAT THEY HAVE READ, AND RECOMMEND TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH FOR ACCEPTANCE, A THESIS

ENTITLED RECOVERED BULIMICS: A SUBSTANTIVE THEORY OF RECOVERY FOR BULIMIA NERVOSA

SUBMITTED BY SHEILA O'BYRNE

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY.

D. T. Shannon-Brady

R. Jevne

C. Yewchuk

F. Walker

S. Wolchik

Date: _____

I dedicate this thesis to the women who participated in this dissertation. They gave much of themselves, in their openness and honesty.

ABSTRACT

The paucity of qualitative research designs examining the issue of recovery from bulimia nervosa led to this study. The question addressed in this dissertation study was "What experiences of recovery from bulimia nervosa, are seen as most significant by the participant?" Based on these experiences a substantive theory of the process of recovery from bulimia nervosa was developed. The psychological and social variables which capture this experience were sought.

Seven participants were interviewed. Their treatments varied: three experienced informal factors and six months or more of formal treatment; two experienced informal factors and approximately two hours or less of formal treatment and two experienced informal factors only. All participants had been recovered for one year or more and none had ever been anorexic, alcoholic, or drug addicted. Their past bulimia was defined according to DSM-IIIR criteria.

The emergent design of grounded theory was used in order to understand the process of recovery from the perspective of the participant. This analysis led to the discovery of a core category, "Opening the Self", defined as a basic psychosocial process (BPSP). Opening the self involved a combination and interaction of psychological as well as social variables. Opening the self was the main theme of recovery from bulimia nervosa. The BPSP is present throughout the theory of recovery.

The analysis of data produced six theoretical codes, opening, self, personal resolve, stages, temporal factor and cyclical pattern. The theoretical codes occurred implicitly

throughout the theory, in varying degrees. The theoretical codes conceptualized how substantive codes related to each other.

The theory of recovery emerged as a four stage theory comprised of twelve substantive codes. The stages were contemplation, action, recovered and maintenance. The substantive codes were realizing the behavior and generating motivation (Contemplation Stage); taking action and subsiding (Action Stage); stopping, choosing health, knowing, relapsing and functioning better (Recovered Stage) and finally, eating, exercising and monitoring feelings (Maintenance Stage). The stages and substantive codes illustrate the phases and characteristics of the recovery process from bulimia.

This theory of recovery can provide valuable information on the process of recovery for bulimics, clinicians and researchers. It can provide a valuable paradigm for research in other eating disorders and addictive behaviors. This study can make a contribution to qualitative research procedures in health psychology because it has demonstrated the grounded theory research process and the emergent theory.

Acknowledgements

The origination of this dissertation has been one of the most challenging and gratifying experiences. It has been in large part, the result of team work and support from loved ones. I am truly grateful to the following people who have shared this experience.

My parents, Michael and Eileen O'Byrne for giving me life and sustenance; for encouraging me to do my best and excel; for providing gentle guidance. I remember my father's words many years ago "Why don't you go and take one Master's course dear!".

Terry, who stood by me every step of the way, with loving support, refusing to allow me to give up, my friend, my mirror, my love.

My committee members: Dr. Dustin T. Shannon-Brady who stood by me from beginning to end; Dr. Carolyn Yewchuk for her support and openness to new ideas, and Dr. Ronna Jevne for her humor, and guidance in qualitative research. To all my committee members for their compassion and patience.

Dr. Sheila Pennington for providing me with a high standard to emulate and an excellent dissertation from which to learn.

My "wombmate" Sean O'Byrne, for always striving to follow his truth and to be his best, and for encouraging me to do the same.

My roommates, Mary Jane O'Byrne for her, humor, sharing and mothering. Lorenzo Oss-cech for his Italian cooking and for being a supportive fellow student; Casey O'Byrne for his knowing I could do it, and Marlene Meiers for her friendship.

My peer group members Judy Chew, Jerry Rose and Caroline Park, for their encouragement, humor, friendship, sharing of ideas and attention to details.

My friend, Paul Lowe for his insight and guidance in the fine tuning of my opening and to all the others such as Elena Van Horssen, Janya Neale, Dr. Paul Koziey, Dr. Don Swatsky and Dr. John Osborne for helping me achieve the opening of my self.

My brothers and sisters, Brock, Laurie, Rory, Keltie, Nancy, Michael, D'Arcy and the rest of my family for always being encouraging, respectful, and loving.

My typist, Debra Fox who became my friend through hard work and good feelings; for Debra's accuracy and speed with limited time (Accuspeed Word Processing).

Lyndsay Clark of the Edmonton Sun for her caring and for publishing two articles plus screening all of the calls.

Finally, my good friends, for always being supportive and sharing their special qualities: Janet for always being there and lending a helping hand; Patti for speaking her mind; Tani for her loving energy; Marcia for her understanding and generosity; Carolini for feeling sisterly; Gillian for many years of friendship and being my "biggest fan"; Tammy for her lightness of being; Matthew for being his beautiful self; Trace for her encouragement; June for her typing; Gary for his expertise, and especially Bianca who encouraged me to take time off, and finally Chris, who shared her beautiful home during my final months of study.

To all of you, I give my deepest thanks.

TABLE OF CONTENTS

CHAPTER I - INTRODUCTION 1

Characteristics of Bulimia Nervosa 1
Recovery from Bulimia Nervosa 2
Purpose 3
Researcher's Interest 3

CHAPTER II - LITERATURE REVIEW 5

Bulimia Nervosa 5
Definition of Recovered 31
Rationale for Doing the Study 34
Grounded Theory 36
Issues of Bias - Identifying Presuppositions 53

CHAPTER III - METHODOLOGY 56

Preparation to Implement the Study 56
Implementation of the Study 59
Establishing Trustworthiness 69
Ethical Considerations 71
Limitations 72
Delimitations 73
Researcher's Presuppositions 73

CHAPTER IV - THEORY OVERVIEW 75

Basic Psychosocial Process: "Opening the Self" 75
The Theoretical Codes 76

CHAPTER V - DESCRIPTION OF THE PROCESS 87

Contemplation Stage 88
Action Stage 91
Recovered Stage 99
Maintenance Stage 107

CHAPTER VI - EVALUATING TRUSTWORTHINESS 112

Evaluating the Theory 112
Trustworthiness 113
Consensual Validation 118
Usefulness of the Theory 121

CHAPTER VII - DISCUSSION OF THE THEORY 123

Secondary Literature Review 123
Becoming Closed and Bulimic 131
Becoming Open 132
Themes 144

CHAPTER VIII - CONCLUSIONS AND IMPLICATIONS 151

Reexamination of Presuppositions 151
Conclusions 153
Implications 156

REFERENCES 158

APPENDICES

A. Description of the Interview Process 172

B. Purpose and Procedures 174

C. Consent Form 176

D. Questionnaire of Demographic Data 178

E. Interview Guideline 180

F. Descriptions of Participants 183

G. External Audit 194

H. Secondary Literature Review 198

CHAPTER I - INTRODUCTION

A major psychological problem existing today in North America is the obsession with body weight. The condition bulimia nervosa has become the most common type of eating disorder treated by psychiatrists and psychologists (Freeman, Barry, Dunkeld-Turnbull & Henderson, 1988).

Characteristics of Bulimia Nervosa

Bulimia nervosa is characterized by recurrent episodes of binge eating and purging. Binge eating refers to the rapid consumption of a large amount of food in a discrete period of time, usually less than two hours. The binge usually includes sweet, high-caloric and easily ingested foods, such as ice cream, candy, cake, doughnuts. The eating is done inconspicuously during a binge. The binge is usually interrupted by abdominal pain, sleep, social interruption or self-induced vomiting. Attempts to lose weight occur repeatedly by restrictive diets and purging. Frequent weight fluctuations occur where greater than ten pounds are gained and lost due to alternating binges, fasts and diets. Most individuals are within a normal weight range, while some are slightly underweight, and others may be overweight. The individual has an awareness that the eating pattern is abnormal and there is a fear of not being able to stop eating voluntarily. Finally, guilt, depression and self-depreciating thoughts follow eating binges (Pope & Hudson, 1984).

Bulimia nervosa is a multifaceted syndrome and its etiology has also been described similarly. No one factor explains the development of bulimia nervosa. It is apparently based on the

interaction of predisposing conditions with precipitating events (Chiodo, 1987).

Recovery from Bulimia Nervosa

Research on recovery from bulimia has been from a treatment and outcome perspective. The research has addressed aspects of internal change on standardized variables. Assessment of internal change from the perspective of the individual has not been addressed. There has been a lack of qualitative research in the experience of recovery from bulimia as well as other health related problems.

Studies addressing the issue of recovery from bulimia nervosa have focused on the measuring of symptom occurrence affected by a particular treatment (Swift, Ritholz, Kalin, & Kaslow, 1987). The purpose of the research has been to discover what treatments work and for whom. This has been very difficult to study, however, because bulimia nervosa's etiology, treatment, outcome and prognosis were found to be highly variable (Theander, 1985). Such quantitative research examined changes on a standardized variable, but did not assess internal change (Parloff, 1984). No research has been completed on individual perceptions of the internal process of recovery resulting from formal treatment or informal factors. An extensive literature review revealed a lack of research on the internal process of recovery from bulimia nervosa using a qualitative approach. As well, in the studies of the recovery process from other health related problems, such as obesity, smoking and alcohol use, there

has been very little qualitative investigation of the experience of recovery.

Purpose

It was the purpose of this study to develop a substantive theory of the internal process of recovery for bulimia nervosa. In order to accomplish this, a qualitative approach was used.

The question being addressed in this study was, "What experiences of recovery from bulimia nervosa are seen as most significant by the participants?"

The grounded theory method was used to examine experiences of recovered bulimics. Persons who previously met DSM-IIIR (1986) criteria for bulimia nervosa were interviewed for the study. To ensure adequate sampling, individuals who had undergone a variety of formal and informal interventions leading to recovery were selected. Data gathered from the participants revealed a core variable or Basic Social Process (BSP). The aim was to discover the BSP in relation to the experience of recovery of recovered bulimics.

Researcher's Interest

The writer chose the topic of bulimia nervosa because of personal interest. The writer experienced mild disordered eating with a binge-diet cycle which was phasic over a ten-year period. Glaser (1978) stated that the research should be fun and "the most fun comes in studying personal life-cycle interest" (p. 28). The researcher may grow from what is being learned and this assists in the completion of the research. Also, there is an advantage to having personal experience in the substantive area being studied,

"The researcher can get crucial insights not only during his research (and from his research) but from his own personal experience prior to or outside it" (Glaser & Strauss, 1967, p. 252). These authors stated that the researcher should deliberately cultivate reflection on personal experiences. Generally, personal experiences are suppressed or given the status of mere opinions. However, they can be seen instead as springboards to systematic theorizing (Glaser, 1978). Since the qualitative research involved the researcher's subjectivity, a section on presuppositions based on previous experiences with bulimia was included.

CHAPTER II - LITERATURE REVIEW

The following literature review is comprised of the characteristics, definition, prevalence and sex differences of bulimia. Also, bulimia is compared to anorexia and obesity, compulsive eating and binge eating, drug and alcohol abuse and addictions. Next, the etiology of bulimia is examined. Finally, treatment, outcome and prognosis are addressed.

Bulimia Nervosa

Research shows that bulimia nervosa usually begins when the individual turns to food for solace because of difficulty dealing with an emotion or situation (Hooker & Convisser, 1983). Food is again used as a comforter on other occasions. Eventually a weight gain becomes a problem and the person chooses to diet. As the dieter begins to restrict certain foods, such as carbohydrates, the craving for food begins. The dieter binges by eating all of the denied foods. Then an even more strict diet is started. Eating for physical need is not considered (Cauwels, 1983). The eating pattern may become fasting all day and bingeing into the night. With the tendency to diet comes a craving for the denied foods. The pattern of physiological responses to underfeeding followed by overeating results in an imbalance in amino acids. This leads to a specific appetite for carbohydrate (McCargar, Clandinin, Fawcett and Johnston, 1988). Thus, further attempts at dieting are antagonized. Further into the disorder, the person turns to laxatives, diuretics and vomiting (Orbach, 1984). Eventually the body deteriorates. For example, salivary glands

swell and teeth begin to have atypical carries and erosion from dehydration and acid. Gastric dilation is very common with even mild cases of bulimia. Hypokalemia may result from vomiting and purging due to loss of body fluids and electrolytes (Russell, 1979).

Depressions are frequent and the perspective of the body becomes distorted. Regardless of whether the body is normal or fat, the person feels fat. Social contacts become less frequent and sexual desire is numbed from the binge-purge cycle. Also, anxiety attacks become more frequent and depression is worse with each binge (Pope & Hudson, 1984; Orbach, 1984; Levenkron, 1982; Roth, 1982 and Cauwels, 1983).

Regardless of whether women are bulimic, overweight, normal weight or underweight, the reason they relate to food and eating is very similar.

> "In general what seems to be true for most women is that they create elaborate eating systems to avoid uncomfortable situations and the unpleasant feelings related to them." (Hooker & Convisser, 1983, p. 238)

In short, food becomes the buffer used to avoid feelings, to fill emptiness, to numb feelings and to be hurtured. Instead of the person using other means to satisfy these needs, they use food (Orbach, 1984).

Definition

The definition of bulimia nervosa according to the Diagnostic Statistical Manual - Revised edition (DSM-IIIR, 1986) reads as follows:

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).

B. A feeling of lack of control over eating behavior during the eating binges.

C. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.

D. A minimum average of two binge eating episodes a week for at least three months.

E. Persistent overconcern with body shape and weight (p. 413).

Prevalence

Bulimia nervosa affects all socio-economic levels, and races although 97 percent of individuals affected are white (Levenkron, 1982). For females the age of onset varies from 11 to 60, most commonly between 13 and 22 (Pope & Hudson, 1984). The exact prevalence of bulimia is unknown (Mitchell & Pyle, 1982). It only becomes apparent when the behavior becomes intolerable to the

individual and the person then seeks help. Most estimates place the disease's prevalence at 1 out of every 250 adolescent girls (Pope & Hudson, 1984). Research on the prevalence of bulimia is extremely limited (Katzman, Wolchik & Braver, 1984). Studies usually examine a sample of a particular population and measure prevalence there. For example, Cooper and Fairburn (1983) sampled 367 consecutive attenders at a family planning clinic. 20.9 percent of the sample reported current episodes of bingeing, 2.9 percent reported vomiting and 4.9 percent reported using laxatives. Applying conservative rules, the authors estimated that 1.9 percent appeared to fulfil diagnostic criteria for bulimia nervosa.

Carter and Duncan (1984) surveyed 421 high school females to determine the prevalence of bulimia. Of the subjects tested, 38 identified themselves on a questionnaire, as self-induced vomiters. Results of this study found the prevalence of bulimia for weight control in a high school female population to be 9 percent. The data are based on self-report and not on direct observation and must be treated cautiously. Katzman, Wolchik and Braner (1984) examined the prevalence of bulimia in men and women in a sample of college students. Subjects were 485 women and 327 men in an introductory psychology course. Results indicated that significantly more women than men reported binge eating and that approximately 4 percent of the college women sampled fulfilled an operationalized criteria for bulimia. The authors suggested that these data supported the hypothesis that bulimia may be a more pervasive disorder than previously suspected.

Sex Differences

Bulimia nervosa is many times more common in women than in men (Cauwels, 1983; Levenkron, 1982; Pope & Hudson, 1984 and Roth, 1984). When it does occur in men, Orbach (1978) suggested that this is due to socio-culturally induced roles and not due to gender differences. For example, when men are oriented to being chosen for their physical attributes such as male models, jockeys and dancers, eating disorders appear. Another factor involves imposed weight, evidenced in sports mandates, as in jockeys and gymnasts. When specific body size is expected in some sports, men too develop eating disorders. Those who struggle with eating disorders are those whose body image or weight is scrutinized. For men, this occurs primarily in sports and for women, bodies are scrutinized by our society.

Despite estimates suggesting 1-6 percent of all college-age men binge (Pyle, Mitchell, Eckert, Halvorson, Neuman & Goff, 1983) there is a lack of research in this area owing to the scarcity of male bulimics in the clinical population. The following two studies address similarities and differences between male and female bulimics.

The clinical characteristics of 15 male and 15 female bulimics were matched as to age, duration of bulimia and frequency of self-induced vomiting (Schneider & Agras, 1987). All participants were given an extensive interview and psychometric evaluations to measure depression, anxiety, assertiveness, and attitudes about food and eating. When they were compared, males had relatively higher current and past weights, greater weight fluctuations, and more realistic perceptions about desired ideal

weight that the women. Males used laxatives, diet pills and restrictive eating less than females. Males reported more present and past problems with drugs and alcohol. There was a statistically significant difference found between men and women on marriage and sexual preference. More women were married and more men reported a homosexual or bisexual preference. The psychometric measures were similar for both groups.

An interesting finding was obtained regarding the social context of bingeing. Males reported being less likely to eat and binge alone while females preferred to binge in private. Males binged at mealtimes and in public places and ate larger quantities of food than the women, at these times.

Schneider and Agras (1987) wrote that these findings suggest that socio-cultural demands for men and women differ. Social cues as to what is overweight, underweight and normal weight result in weight thresholds that differ for the two sexes.

Fifteen bulimic men who had been treated by the ors or their associates over the preceding three years, were compared to a group of 102 bulimic women at the same center (Pope, Hudson & Jonas, 1986). The two groups were compared on demography, associated psychopathology, family history, and treatment response. A personal history of affective disorder, a family history of affective disorder and response to antidepressant medications in male bulimics were comparable to those found in female bulimics. This study found an older age of onset in males compared to females. The study was unable to determine a higher prevalence of sexual abnormalities in males. The authors conclude

that if major differences exist between bulimic men and women, more sophisticated studies will be required to elucidate them.

In summary, it appeared from the studies that bulimic men and women were similar in regard to psychometric measures (Schneider & Agras, 1987), personal and family histories of affective disorders and response to anti-depressant medications (Pope, Hudson & Jonas, 1986). They differed in weight histories, problems of alcohol and drugs, eating and purging practices (Schneider & Agras, 1987), and age of onset of bulimia (Pope, Hudson & Jonas, 1986). Schneider and Agras (1987) found that marriage and sexual preference differed for the men and women. Pope, Hudson & Jonas (1986) found no such evidence for differences in sexual preference.

Bulimia Nervosa, Anorexia Nervosa & Obesity

Bulimia nervosa is not always simply bulimia. It sometimes has characteristics of anorexia nervosa, becoming a mix of the two eating disorders. For example, Levenkron (1982) named 3 categories of eating disorders. The first is anorexia nervosa, which is characterized by intake limiting. This involves a very low intake of calories, from 300 to 600 per day. A full stomach is equated with obesity. Fears of overeating and of abdominal distention become an added factor. The second category is anorexia/bulimia. This is characterized by alternate bouts of starving and eating. The cycles vary in length where some individuals will for example, starve all day and eat for hours at night. Mood swings are created by the rise and fall of blood sugar levels, due to the bingeing foods high in sugar and

carbohydrates. These contribute to general emotional chaos and feelings of incompetence. According to Levenkron (1982) this pattern may resolve itself in six months or continue indefinitely. The third category is bulimorexia. This term refers to women who may consume up to fifteen thousand calories in a day and then vomit in order to avoid weight gain. The women vary from emaciated to normal. The individuals become attached and addicted to purging.

Not only are the disorders overlapping, but when examined separately, there are resemblances. For example, since 1986, the DSM-IIIR has used the term "bulimia nervosa" instead of "bulimia" to reflect the strong relationship of the disorder to anorexia nervosa. Also, research with the Eating Disorders Inventory (EDI) indicated that anorexia nervosa and bulimia patients resemble each other in profile features and overall pathology scores (Fairburn & Cooper, 1984). In addition, it has been found in a study that bulimic women with anorexia nervosa (N=59) and bulimic normal-weight women (N=59) resembled each other on most variables and were more similar to each other than to women with anorexia nervosa who rigidly restricted food intake (N=59). These results do not support a diagnostic distinction between bulimia in anorexic women and bulimia of equal severity in normal-weight women (Garner, Garfinkel and O'Shaughnessy, 1985).

Researchers are examining bulimia nervosa in relation to obesity because there are obese women who are bulimic (Orbach, 1984). For example, in a study by Williamson, Kelley, Ruggiero and Blouin (1985), bulimic and obese people showed some

similarities in eating habits and psychopathology, especially regarding obsessiveness, impulsivity and guilt.

Bulimia, anorexia and obesity all reflect a strong preoccupation with weight and dissatisfaction with body image. Another similarity between bulimia nervosa and obesity involves dieting where individuals attempt to lose weight (Orbach, 1978 and Polivy & Herman, 1987). Dieting produces a disrupted eating pattern. Although not all dieters have an eating disorder, dieters with an intensified quest for a slim body frequently develop anorexia nervosa.

Differences appear between bulimia, anorexia and obesity. All three involve different types of disordered eating. Bulimics eat too much at one time and too little at others. Anorexics eat too little. The obese eat too much (Polivy & Herman, 1987).

The three types of persons diet for different reasons. Bulimics diet to become what is considered the "perfect" size. The individuals use an external indice rather than internal knowing (Orbach, 1984). Anorexics diet as a means of regressing to a prepubertal body shape in order to avoid growth and development (Crisp, 1965). The obese diet in order to cope with feelings of ineffectiveness and to reduce body size (Bruch, 1973).

The three types of disordered eating involve different views of body-image. Bulimics tend to consider themselves as fat when they are usually of average size. Anorexics see their emaciated bodies as fat. The obese are aware of being fat (Reiser, 1988).

Finally, different feeling states occur. Bulimics evidenced significantly more depression and anxiety than the obese (Williamson et al., 1985). Anorexics are characterized as denying

their illness, exhibiting apparent enjoyment in losing weight and feeling a sense of effectiveness. The obese are characterized as depressed and anxious (Brone & Fisher, 1988).

Comparisons Between Bulimia, Compulsive Eating and Binge Eating

The literature demonstrated varying views on the process of comparing bulimia with compulsive eating and binge eating (Wardle, 1987 and Kateman & Wolchik, 1984).

Wardle (1987) wrote that compulsive eating and binge eating are terms used to describe a disturbed eating pattern with an excessive food intake, a continuous preoccupation with food, craving particular foods, and going on eating binges. In some cases, the eating behavior is followed by self-induced vomiting, which relieves gastric fullness and averts weight gain. When the binge eating is severe and accompanied by a profound fear of fatness, it is defined as bulimia nervosa (DSM-IIIR, 1986).

Katzman and Wolchik (1984) wrote that it is important for researchers to be cautious about generalizing from the results of the studies of bulimics and binge eaters as there are differences on a number of characteristics. In a study by Katzman and Wolchik (1984) it was found that bulimics demonstrated greater dieting concern, more binge eating behaviors, lower self-esteem and poorer body images than binge eaters. Also, bulimics demonstrated greater need for approval and greater depression then binge eaters.

It seems that the differences between bulimics and binge-eaters lie in the severity of the characteristics. Even though there are differences in degree of symptomatology, there are

commonalities between bulimia and disordered eating. Both have excessive concern around patterns of eating and are characterized by psychological problems associated with the self-image. Comparisons should still be made with some caution.

Bulimia Nervosa and Drug and Alcohol Abuse

It was found from the literature review on bulimia nervosa, that a percentage of bulimics and persons at risk for developing bulimia abused drugs and alcohol.

Dykens and Gerrard (1986) found that undergraduate women classified as bulimic engaged in drug and alcohol use more frequently and at an earlier age than did non-bulimic controls. Killen, Taylor, Telch, Saylor, Maron and Robinson (1987) found that high school females who reported purging, engaged in day time drinking and drunkenness more than female non-purgers. The female purgers were not diagnosed as bulimic as less than 1 percent purged more than once a week. Bingeing frequency was not examined. These females were considered as being at risk for developing bulimia.

Hatsukami, Eckert, Mitchell and Pyle (1984) evaluated 108 women with bulimia for alcohol and drug abuse. In the sample, 18 percent had a history of alcohol or drug abuse. The women were seen following routine referrals to the University of Minnesota Eating Disorders Clinic.

Killen et al., (1987) suggested that the development of purging and other compensatory behaviors such as drinking may occur because of increased susceptibility to psychological difficulties. These studies demonstrate that bulimia is sometimes

accompanied by other compensatory behaviors such as drinking and drug use.

The articles did not address differences in bulimics and bulimics using drugs and alcohol. For some unknown reason some individuals are bulimic and some are bulimic and abuse drugs and alcohol. From clinical observation, it appears that different people prefer the effects of different substances. This may partly explain why some bulimics abuse drugs and alcohol and some do not.

Comparisons Between Bulimia Nervosa and Addictions

Sometimes bulimia nervosa is not used in comparison to substance addiction, but instead binge eating, compulsive eating or disordered eating.

Bulimia and substance addictions share the commonality of bingeing (Pyle et al., 1983). In both disorders persons attempt to exert self-control, experience a powerful drive to consume and then binge (Wardle, 1987). Likewise, they share symptoms of being preoccupied with the substance, losing control over substance intake, a concern expressed by others and continued problematic consummatory behavior in spite of negative consequences (Scott, 1983). Also, these problems are characterized by the individuals having difficulty coping with feelings and external events (Wardle, 1987).

Bachman and Röhr (1983) wrote that targets of therapy for both psychogenic eating and alcohol addictions are motivation, insight into one's condition and addressing causes. The reason that both share treatment targets is because of the similarities

of the physical and emotional disturbances of withdrawal symptoms such as tremor, profound perspiration, states of restlessness, strong depressions and fears. Wardle (1987) wrote that similar treatment strategies have been used both in the treatment of compulsive eating and addiction. For instance, the use of drugs to control appetitive drive and the use of cognitive behavioral strategies to control craving.

It appears that differences between bulimia and drug and alcohol addiction begin in the etiology. Persons tend to become bulimic as a means of coping with feelings and events (Orbach, 1984 and Hooker & Convisser, 1983). Persons tend to become addicted to drugs and alcohol at first by using the substances for pleasure, and then for coping which lead to addiction (Wardle, 1987). Social situations differ markedly for engaging in bulimic behavior and substance abuse. For instance, binge eating was found to be triggered by temptation and conflict while alcohol and substance abuse were elicited more strongly by social situations and social pressure to use (Filstead, Parella and Ebbitt, 1987). Treatment goals differ for bulimia and for substance addiction. An essential feature of treating eating disorders is to encourage individuals to meet their physical need for food thereby alleviating craving and preoccupation with food. In the treatment of substance addiction, abstinence is encouraged. Thus treatment goals vary with moderation of food intake and abstinence of substances (Wardle, 1987).

Summary. The similarities between bulimia and addictions were bingeihg, symptom such as a preoqcupation with the substance, using because of difficulty coping, similar targets of therapy

because of common withdrawal symptoms, and similar treatment methods. Differences addressed were reasons for engaging in the behaviors initially, social acceptance and treatment goals.

The strong similarities between bulimic nervosa and substance, not over-looking the differences, suggest that a general model of recovery needs to be sought.

Etiology of Bulimia

The preponderance of bulimia nervosa in women has been explained from socio-cultural, biological, interactional and genetic perspectives. The socio-cultural theory states that there is an increasing pressure for women to be thin in a more and more weight conscious society. Pope & Hudson (1984) found that over the last twenty years the average weight of Playboy centerfold women has declined by 8 percent. Miss America Pageant contestants have grown thinner and the number of diet articles in six popular women's magazines had doubled in the last twenty years (1984). The authors concluded that the socio-cultural theory alone seems unable to explain the underlying cause of bulimia nervosa in women. Other factors besides pressure to be thin must be taken into account to explain the development of bulimia.

The biological theory states that there is possibly a biological abnormality in the form of hypothalamic dysfunction (Gwirtsman, Roy-Byrne, Yager, Gerner, 1983). Perhaps the hypothalamus or some other part of the central nervous system related to eating behavior is more easily affected in women than in men (Pope & Hudson, 1984). The hypothalamus serves in a regulatory capacity over sleeping, eating, body rhythms,

temperature and sexual function. More specifically the hypothalamus affects heart rate, respiration, blood chemistry and glandular activity. Also, the hypothalamus has a very important role in regulating the immune system. The functioning of the hypothalamus can be affected by behaviors such as eating, drinking, exercise and thinking (Achterberg, 1985). It seems that whether or not there are abnormalities in the hypothalamus, eating behavior affects its functioning. In turn, the hypothalamus regulates eating. The question arises as to what comes first, the dysfunctional hypothalamus or dysfunctional eating? Hypothalamic functioning by itself does not explain the entire symptom picture of bulimia nervosa (Pope & Hudson, 1984).

Another explanation for bulimia nervosa focuses on factors within the family. Bruch (1973) proposed that an overcontrolling family prevents the child from becoming attuned to the rhythm of his or her own bodily needs. The child then experiences an overall lack of awareness of living his or her own life and controlling his or her own functiens. There is a conviction of the ineffectiveness of all his or her efforts and strivings. Bruch (1973) suggested that bulimia arises as part of the struggle to gain control over one's functions during adolescence. If the struggle for self-control for a child from an over-controlling family fails, the development of bulimia may occur.

Pope & Hudson (1984) reviewed dozens of studies where the parents of anorexics with or without bulimia, were exanined. Since the studies did not include parents of purely bulimic children, they can only provide an approximation of what might be found. Pope & Hudson (1984) found no consistent evidence and

concluded that if common personality patterns are to be found in these families, they must be at a more subtle level.

Finally the genetic component is considered as a cause of bulimia nervosa. Pope & Hudson (1984) reported on dozens of family studies where the parents of anorexics with or without bulimia were examined. Again, since the studies did not include parents of purely bulimic children, they can only provide an approximation of what might be found for bulimics. Obsessionality was observed in 29 percent of fathers and 14 percent of mothers. This trait may have nothing to do with causing bulimia in the child, but may indicate that the father or mother shares with their child a certain commonality, that may have roots in genetic make-up. It is noteworthy that the percentages reported in this study are rather small on which to base a causal explanation.

In conclusion, bulimia nervosa is a complex eating disorder that cannot be explained easily. It is a multi-faceted syndrome with a multi-faceted etiology.

Treatment, Outcome and Prognosis

Different treatment strategies focus on changing behavior patterns and resolving underlying psychological and emotional factors related to bulimia. A more balanced eating style is the goal of treatment. Treatment strategies include family therapy, behavior based cognitive and experiential therapy, psycho educational therapy and comparisons between various therapeutic approaches. Pope and Hudson (1984) have reported numerous approaches in treating bulimia nervosa, but few studies have examined only outcome or prognosis.

Treatment. Family studies of the treatment of bulimia are very rare. Pope and Hudson (1984) found only a few studies on the effectiveness of family therapy with anorexics. They report on one study done by Minuchin, Rosman & Baker (1978). The effect of treatment was positive. Eighty-eight percent of patients returned to normal eating patterns. Pope & Hudson (1984) concluded that there is little scientific evidence that family therapy is effective with bulimia. This does not mean that such therapy is ineffective.

Behavior therapy may include positive and negative reinforcements. For example, bulimics may be rewarded for not bingeing or vomiting and punished for bingeing and vomiting. Behavior therapy may focus on teaching helpful behavior modification strategies such as keeping track of food eaten in a daily journal. Fairburn (1981) produced a quantitative study of behavior therapy in bulimics. He treated 11 bulimic women with standard behavior therapy techniques and included in his treatment cognitive therapy. Using cognitive therapy the bulimics were trained to challenge and replace maladaptive thoughts. Fairburn (1981) stated that 9 of the 11 women stopped bingeing after three to twelve months of this treatment. Results held up on a follow-up of four to twelve months.

Boskind-White & White (1981) have published two reports. In the first, 12 college women with bulimia were treated in 11 two-hour sessions, with a six-hour session midway through treatment. The behaviorial component consisted of contracts, assertiveness training, sensory-awareness exercises and a personal daily journal to record feelings and events before binges. The experiential

component involved discussing issues, sharing feelings, and the development of friendships. At the end of the eleven-week group treatment, 4 women reported no more bingeing, 6 reported less frequent bingeing and 2 were unchanged.

The second study involved a five-day intensive treatment involving 5 hours of group therapy per day, divided into morning and afternoon sessions. The subjects were 14 women. Group therapy employed fewer behaviorial and more experiential elements than in the preceding study. The study lacked methodological soundness as pre- and post-measures were not used. White & Boskind-White (1981) stated that after 6 months, 3 women had ceased to binge, 7 had less frequent binges and 4 were unchanged.

In all of the above mentioned studies, methodological weaknesses were present. They each lacked in the use of control groups and methods of blindness, where outcome is rated by an investigator blind to the treatment or procedures used. The validity of the studies is thus questioned.

Another treatment approach is the psychoeducational group treatment program (Wolchik, Weiss & Katzman, 1986). Common aspects include developing alternative ways of coping with events and feelings that are associated with binge eating, attention to irrational concerns about shape and weight, and self-monitoring of eating binges. The focus of the psychoeducational program is on the enhancement of personal competencies such as building self-esteem, establishing more realistic goals in aspects of life and developing assertion skills. In the Wolchik et al., (1986) study, the effectiveness of the psychoeducational group treatment program for bulimia was examined. A seven-week program was both didactic

and experiential. Each session focused on a topic that addressed a personality or behaviorial deficit associated with research findings on bulimia. Women who received treatment (N=11) showed significant improvement in their bulimic behavior in addition to improvement in self-esteem and depression relative to no treatment controls (N=7). This program was less effective for 3 of the women. One limitation of the study is that the sample was small. Replication of the findings would be useful (Wolchik et al., 1986).

In another study by Morin et al., (1987) the relative efficacy of 2 major clinical procedures was compared, the behavior procedure of exposure plus response prevention, and cognitive intervention. The procedure of exposure plus response prevention involves the individual bingeing on preferred foods, experiencing the desire to vomit and receiving help from the therapist in order to learn how to prevent the vomiting response. The cognitive procedure involves the individual and the therapist discussing ways of coping with bulimic behavior. A single-subject experimental design was used to measure differences in the procedures. Results showed that the exposure plus response prevention was more effective than the cognitive procedure in reducing bulimic behavior. The authors concluded that performance-based components have a higher impact on bulimia nervosa behavior change than cognitive procedures. Also, they suggested that clinical benefits obtained from multi-component treatment programs were probably due not to cognitive strategies but to the incidental use of performance based behaviorial components.

Studies examining the relative efficacy of different treatment modalities indicate that positive results were produced from a number of treatment approaches. Freeman et al., (1988) found encouraging findings in a randomised controlled trial of different types of psychotherapy for 92 bulimics. Women were assigned to receive cognitive behavior therapy, behavior therapy or group therapy which was described as supportive and educational in orientation. Cognitive behavior therapy was described as the women learning about the function of their thinking patterns related to their bulimic behavior. Behavior therapy was described as the women learning ways to cope with eating patterns. All three treatments were effective in reducing bulimic behavior.

Russell et al., (1987) evaluated family therapy compared to individual therapy. Individual therapy was described as supportive, educational and problem-centered with cognitive and interpretive elements. The authors found that generally family therapy was more effective for younger bulimics and individual therapy more effective for older bulimics.

Fairburn, Kirk, O'Connor, Anastasiades and Cooper (1987) compared a cognitive behavioral treatment to a form of short-term focal psychotherapy in examining prognostic factors. The treatments were not described by the authors. Both treatments were considered as being equally effective in the treatment of bulimia.

In a study by Lacey (1984) a principle of treatment was that overt symptoms need to be dealt with by initial behaviorial treatment. Emotional conflicts thereby released, need to be examined within insight-directed therapy. Lacey (1984) found in a

controlled study that 24 of the 30 patients studied, had stopped their symptoms completely by the end of the 10 sessions using this principle of treatment.

Treatment approaches deal with emotions, past conditioning creating dysfunctional patterns, and issues around eating such as hiding binges. Most treatment approaches work to some degree and a combination of treatments is better than one treatment alone (Pope & Hudson, 1984). Johnson, Connors & Stuckey (1984) found that preliminary findings regarding the case of short term group treatment indicate that most subjects reduce the frequency of their bulimic behavior after treatment. According to Stevens & Salisbury (1984) few bulimics are cured but most experience a reduction of symptoms.

Outcome. The purpose of outcome studies is to examine the effects of treatment by using short and long term follow-up studies (Theander, 1985). There is a dearth of follow-up studies on bulimia (Swift et al., 1987). Also lacking are studies of outcome for bulimics who did not receive treatment but managed to help themselves recover.

Ordman and Kirschenbaum (1985) studied the effectiveness of a 5 month cognitive behavioral therapy program for 10 bulimics immediately following treatment. A control group of 10 bulimics was used which consisted of 3 brief assessment sessions. Therapeutic interventions were used which consisted of an educational component about the maintenance of bulimia and behavioral strategies used for coping. The control group was assessed 5 months following the interviews. Clients who received the cognitive behavioral treatment improved much more than those

in the control group. Individuals in the treatment group made great strides, however 3 of the 10 were still bingeing and vomiting more than once per week at follow-up; although 7 had reduced their bingeing and vomiting to 1 day per week or less, only 2 had completely stopped. Participants in the control group did not improve. The authors suggested that cognitive behavioral therapy is a promising approach as the women demonstrated a reduction in the urge to vomit.

Swift et al., (1987) carried out a follow-up study on 30 normal weight female bulimics, two to five years following hospital admission. Using semi-structured interviews and psychometric measures they found that symptom intensity was greatly reduced following treatment. Treatment is described as occurring in the context of a rich treatment environment in which psycho-therapeutic, educative and rehabilitative modalities were employed. The main duration of hospital stay for the women was 24.2 and 9.2 days. Eighty-seven percent of patients continued to meet DSM-III criteria for bulimia at follow-up. The authors wrote that symptom intensity was greatly reduced after receiving treatment.

Abraham, Mira and Llewellyn-Jones (1983) assessed outcome for 43 bulimics 6 years after presenting for treatment. Treatment consisted of counselling about binge eating and supportive therapy such as helping the women cope with marital problems or low self-esteem. Treatment was individual and varied from 14 to 72 months. Outcome demonstrated that 29% to 42% of patients could be considered "cured". The authors attributed the lack of consistency in the findings to differences in the patient's self-

rating and the rating. They suggested a need for the patients to feel improved but not cured.

Prognosis. Another purpose of outcome studies is to search for prognostic factors. The word prognosis literally means pre-knowledge. According to Funk and Wagnall's Standard Dictionary (1980), prognosis is defined as "a prediction or conclusion regarding the course of a disease and the probability of recovery" (p. 635). The physician or therapist, in the process of making a prognosis in an eating disorder, currently receives little guidance from outcome studies. At present, prognoses are often made intuitively (Theander, 1985).

The few studies on the general course of bulimia nervosa have reached similar conclusions. The general course of bulimia nervosa is phasic and changes its pattern over time. For example, it can be very typical at one time and atypical at another time and vice versa (Theander, 1985). It can improve and then a regression can occur (Garner, Fairburn and Davis, 1987). Bulimia nervosa follows a prolonged course (Russell, Szmukler, Dare, & Eisler, 1987).

The probability of recovery has been studied in two ways. First, extensive histories of bulimics who participated in outcome studies are taken. Second, other studies focus on completers and dropouts. Outcome studies involving historical factors examine age of onset, duration, severity, demographic variables, history of anorexia nervosa, family histories and psychiatric histories.

Russell et al., (1987) completed an evaluation of family therapy compared with individual therapy. It was found that family therapy was more effective than individual therapy in

patients whose illness was not chronic and had begun before the age of 19 years. Another finding identified the greater value of individual therapy for older patients.

Fairburn et al., (1987) examined prognostic factors from the data in a controlled study of the treatment of bulimia nervosa. Outcome was assessed at 4 points during a 12-month, treatment-free follow-up period. A cognitive behaviorial treatment was compared with a form of short-term focal psychotherapy. To determine what factors influenced the response of these patients to treatment, the relationship between certain pre-treatment variables and outcome was examined at each of the assessment points. At the final assessment point, no differences in outcome were found between those who had a history of anorexia nervosa and those who had no such history. The pre-treatment level of depressive symptoms also did not correlate significantly with outcome. Other factors examined to determine prognosis were length of history and age at onset of bulimic episodes, self-esteem, neuroticism and social adjustment. The authors found that no consistent predictor variables existed except for self-esteem, where patients having low pre-treatment self-esteem responded least well to treatment.

Bulimics with a history of anorexia nervosa are considered to be more difficult to treat than bulimics with no such history (Lacey, 1984). Garner, Fairburn and Davis (1987) did not find this characteristic to be predictive of outcome.

The second way to study prognosis is to compare completers with dropouts. Completers are individuals who completed treatment. Dropouts are individuals who dropped out of treatment prematurely. In Theander's (1985) study of previous outcome

investigations, he found that dropouts were older, had longer histories of illness, were of lower socio-economic status and had less education. Garner et al., (1987) wrote that dropouts have been found to have a greater pre-treatment frequency of bingeing and vomiting, and report more anger and depression on standardized tests. In a study by Roy-Byrne, Lee-Brenner and Yager (1984) dropouts never really committed themselves to the group. In the Russell et al., (1987) study comparing family therapy with individual supportive therapy, patients over 18 years of age tended to remain engaged in treatment if the therapy was individual rather than family. Also, there was greater tendency for patients 18 years of age or younger with a duration of illness less than three years to drop out of treatment if they had been allocated to individual therapy (7 of 11) rather than family therapy (1 of 10).

Finally, Merrill, Mines and Starkey (1987) studied persisters versus dropouts across 6 bulimia groups. Persisters are individuals who remained in treatment past the twentieth week. A total of 53 women from 18 to 48 years of age who met DSM-III (1980) criteria for bulimia were examined; 20 participants dropped out prior to the twentieth week of therapy. The groups consisted of 1 psychotherapy group, 3 cognitive-behaviorial groups and 2 feminist groups. The group treatments were not described in the article. Groups ran from 30 to 40 weeks.

Of the 6 groups, 3 had dropout rates of approximately 50 percent, and the other 3 groups lost only 1 or 2 members. The group with the lower dropout rate had leaders who were more experienced. The most common reason given for dropping out was

that the subject did not believe the group could help her bulimia. Other reasons given for dropping out was frustration over perceiving no change, feeling that they did not fit in with group members, and being afraid to interact in the group.

Demographically, dropouts were younger than persisters and were less likely to be employed, married or sexually active. The authors hypothesized that dropout subjects tended to be less mature and may have been more socially isolated. There was no correlation between the Beck Depression Inventory or binge-purge frequencies.

The authors concluded that the dropout subjects were less able to make commitments to others or that they had not experienced their disorder long enough to be in as severe distress as the persisters.

Summary. Treatment studies demonstrated that most treatments work to some degree. Many studies reported combinations of treatments which demonstrated some success in treating bulimics. Studies on outcome demonstrated that most bulimics experience a reduction of symptoms. Prognostic studies demonstrated variations of the effectiveness of treatments on factors such as chronicity of illness, age and level of self-esteem. A difference was found on whether or not bulimics with a history of anorexia are more difficult to treat than bulimics without anorexia. Finally, dropout, completer and persister characteristics differed across all studies examined.

In examining the issue of recovery, research demonstrates a focus on treatment, outcome and prognosis. The purpose of the research has been to determine what works and for whom. The issue

of recovery has not been examined from the perspective of the individual.

Definition of Recovered

It is well known that there is great variability in the course and outcome in treated as well as untreated bulimics (Theander, 1985). In defining recovered, there is little agreement on what is appropriate criteria. Two criteria which have been reported are general outcome categories and length of recovery.

Categories Defining Recovered

Russell, Szmukler, Dare and Eisler (1987) devised general outcome categories of good, intermediate and poor. The term recovered or cured is not used. "Good is defined as: no bulimic symptoms, no episodic over-eating nor self-induced vomiting. Intermediate is defined as: bulimic symptoms are present but occur less than once weekly. Poor outcome is defined as: bulimic symptoms occur more frequently than once weekly" (p. 1047).

Swift, Ritholz, Kalin and Kaslow (1987) used the categories, good, intermediate and poor for describing outcome. They wrote that cure in bulimia nervosa is very rare and in this study of outcome, 87 percent of bulimics continued to meet DSM-III criteria for bulimia at follow-up. The authors added, however, that the mean decrement in frequency of bingeing episodes per month from admission to follow-up was 84 percent and the mean decrement in vomiting was 76 percent (1987).

One outcome study used the term cured. Outcome was assessed for 43 bulimic patients 14 to 72 months after presenting for

treatment. Abraham, Mira and Llewellyn-Jones (1983) stated that 29 percent to 42 percent of patients could be considered cured. The criteria used in the classification of cured were:

> No binge eating or binge eating less than once per month.
> No self-induced vomiting.
> No laxative use for weight loss, weight control, or abdominal fullness.
> No other weight-control or weight-losing behaviors, but watching what I ate was allowed.
> A stable body weight (±13 kg) (p. 176).

Again, binge eating less than once per month is permissible for a bulimic who is considered cured.

Cooper and Fairburn (1987) were more strict in their criteria for determining recovered bulimics. The authors claim that even though bingeing and purging may have stopped psychopathological traits may still remain such as extreme concerns about shape and weight. They developed a semi-structured interview, Eating Disorder Examination (EDE), to assess the psychopathology of bulimics who no longer binge or purge.

Length of Time Recovered

Length of time is another criterion considered in defining recovered. There is much variation in the time frames used for determining recovered. When doing outcome studies there are varying opinions of how long a person needs to be symptom free in order to be considered suitable for interviewing.

Swift et al., (1987) wrote that a minimum of 2 years for medium follow-up and a minimum of 4 years for long-term follow-up studies are well suited to determine if bulimia is responsive to treatment.

Garner, Fairburn and Davis (1987) stated that follow-up must occur after no less than one year. Most short-term follow-up periods are inadequate as a significant proportion of individuals remain symptomatic at post-treatment and at follow-up. In their opinion a three to four year evaluation is optimal. Bulimia nervosa is characterized by chronicity and a fluctuating course, thus optimal time is necessary in order for stability to occur.

Russell et al., (1987) stated that a four or five year follow-up is necessary to ascertain outcome as the eating disorder follows a prolonged course.

Criteria Defining Recovered

It is well-known that there is great variability in the course and outcome in treated as well as untreated bulimics (Theander, 1985). In view of the differing research on the definition of recovered for bulimia and from the writer's experience with disordered eating and bulimic clients, the following criteria are considered to define recovery. First, persons must be recovered for one year or more (Garner, Fairburn & Davis, 1987). Second, they deem themselves recovered and may binge occasionally, such as once per month (Abraham et al., 1983). It is noteworthy that any definition of recovered does not necessarily imply permanent cure.

Rationale for Doing the Study

The purpose of the study was to examine the experiential process of recovery from bulimia nervosa. An investigation of the process of change needs to account for the person's internal experience of that process. Much of the research originating in the quantitative paradigm fails to account for the person's experience. Quantitative studies measure aspects of internal change, not processes of change. Studies of bulimia include general psychological factors and psychopathological traits of the eating disorder. These factors and traits are established by pre- and post-treatment measurements. For example, psychological traits such as depression (Sohlberg, Rosmark, Norring, & Holmgren, 1987), anxiety (Chiodo, 1987) and self-esteem and assertiveness (Connors, Johnson, Stuckey, 1984), are considered as factors of internal change. Psychopathological traits such as spitting of food, rumination, feelings of fatness and so on, are considered to assess internal change (Cooper & Fairburn, 1987, and Johnson et al., 1983). Also, the studies have examined changes within a formal treatment program. These studies have not taken into account the person's experience of the process of recovery. The lack of knowledge concerning what is perceived to happen within a person during formal treatment (May, Angel and Ellenberger, 1958 and Parloff, 1984), and a person who changes informally (Parloff, 1984; Theander, 1984) encouraged the development of this study.

Rationale for Using the Qualitative Paradigm

Quantitative methods fail to examine the person's experience of the process recovery. Quantitative methods are riddled with

methodological difficulties which plague the interpretation of results. Problems with standardized interventions, definitions, therapist experience and sampling are four issues that Garner et al., (1987) and Parloff (1984) address. Another methodological issue discussed by Parloff (1984) is the attempt to assess internal change.

Garner et al., (1987) reviewed cognitive - behaviorial (CB) treatment methods, reporting on their efficacy with bulimia nervosa. Although results are encouraging, the authors found that few studies depended on manuals to standardize interventions. There were inconsistent definitions of CB methods. In some of the studies, experienced therapists were used, while in others, graduate students were employed. In some, recruitment depended on advertisement and in others clinical referrals were used, making for very diverse subject populations.

Parloff (1984) examined similar methodological issues pertaining to reviews which confirmed that all psychotherapies produced significant therapeutic results. No studies on bulimia were included in the reviews. He found that the research focused on classes of therapists and not specific techniques. He was critical of the fact that the therapist used in the studies were mostly novices who had not completed their Ph.D. training. In most of the studies, subjects were recruited mainly by the investigators. The subjects were not actively seeking treatment. These issues were common to psychotherapy literature reviewed.

Both articles demonstrate that because of these methodological issues, conclusions which can be drawn are limited. Parloff concluded that "The measurement of results is currently

the most poorly executed" (1984, p. 107). Parloff's statement may be applicable to the bulimia nervosa research.

The difficulties with present quantitative research methods (Garner et al., 1987 and Parloff, 1984) and the fact that these types of studies do not attempt to assess internal change (Parloff, 1984), led to the researcher concluding that there was a need to use a qualitative research design to examine the experience of recovery from bulimia nervosa. A study of the literature on research methodology indicated that grounded theory was an appropriate way to examine the topic of recovery from bulimia.

Grounded Theory

Grounded theory is "the systematization of the collection, coding and analysis of qualitative data for the generation of theory" (Glaser & Strauss, 1967, p. 18). Grounded theory is initially phenomenological. It studies human experience. The discovery of the experience is achieved by means of detailed description. Phenomenology would stop at the point of description, emphasizing an individual's lived experience (Giorgi, 1970). However, grounded theory goes a step further in the generation of a theory grounded from the description using the constant comparative method and the insights of the researcher (Glaser & Strauss, 1967). Grounded theory is a useful method of explaining data through emergent theory.

The Pennington (1981) study is an example of the flexible use of grounded theory's emergent design. Her study examined the internal process of recovery for cancer patients who survived

after being given a prognosis of inevitable death within two years. A loosely structured interview schedule was used. During the interview, the questions were open-ended and not rigidly adhered to (Chenitz & Swanson, 1986). Rather, using the constant comparative method (Glaser, 1978) questions and concepts were formulated as the interviews progressed.

Symbolic Interaction

The grounded theory paradigm is based on the "symbolic interactionist perspective", whereby meaning must be understood from the perspective of the participants and behavior must be understood at the symbolic and interactional levels (Chenitz & Swanson, 1986, p. 6). The concern is with the study of the inner or experiential aspects of human behavior. Thus, the focus is on the interaction in a situation; for example, the experience of recovery from bulimia nervosa in relation to the interpretation of the events related to recovery. The symbolic meanings that are interpreted relative to the experiences will determine the actions of the participant.

Rationale for Using Grounded Theory

The purpose of this study was to develop a substantive theory of the process of recovery for bulimia nervosa. In order to accomplish this, the writer used her interpretation of grounded theory as proposed by Glaser (1978) and Glaser and Strauss (1967). This qualitative methodology was chosen as most suitable to investigate individuals' experience of the recovery from bulimia nervosa because of its systematized methodology and its emergent design. Grounded theory provides explanatory conceptualization of

the data helpful to understand the different processes involved in recovering.

Formal and Substantive Theory

Grounded theory can be used to generate two basic kinds of theory, formal and substantive. By formal, it is meant that the theory is developed for an area of inquiry across different types of units. For example, an area of inquiry such as emergencies would be studied across different units, such as hospital emergency wards and fire departments. A high degree of apparent difference exists between hospitals and fire departments and yet both units deal with emergencies. By substantive theory, it is meant that the theory is developed according to an area of inquiry for one type of unit. For example, an area of inquiry such as emergencies would be studied only in hospital emergency wards. In the case of the present study, recovery was studied according to the substantive area of bulimia. Formal theory, which could be done at a later date, could involve sampling recovered alcoholics, drug addicts, or people recovered from some other consummatory behavior (Killen, Taylor, Telch, Saylor, Maron, & Robinson, 1987). Substantive theory can contribute to an indepth understanding of the recovery process with bulimics. This may become a stepping stone to the development of a grounded formal theory (Glaser & Strauss, 1967) that covers other types of recovery from behaviors involving consumption of a substance.

Constant Comparative Method

The constant comparative method is the systematization of the method of grounded theory. The steps of the constant

comparative method are the collection of research data, open coding of the data, theoretical sampling, generating many memos and the emergence of a core variable. The core variable becomes the basis for more selective theoretical sampling, coding and memoing (Rennie, Phillips & Quartaro, 1988). These steps occur all at once, and while the researcher keeps doubling back to more data and coding, the emphasis keeps shifting toward more memos on data and memos on memos (Glaser, 1978). As the saturation of memos begins to occur, the researcher turns to sorting. Memos are sorted into theoretical frameworks by the constant comparative method. Eventually, the researcher begins writing up the data.

Collection of data. Chenitz and Swanson (1986) addressed the interview as an important aspect of data collection in grounded theory. There are two types of interviews. First, is the informal interview which is like an everyday conversation. It is commonly used to collect data from the natural world in order to "see" this world as the interactants see it (Chenitz and Swanson, 1986, p. 79). Second, is the formal interview that consists of unstructured and structured formats. Unstructured interviews include an interview guide containing a set of brief, general questions. A guide is used to clarify the general areas about which the participant will be asked. Questions are open-ended and not rigidly adhered to (Chenitz & Swanson, 1986). Structured interviews involve the use of an interview schedule where the interviewer does not deviate from the questions in sequence or wording. Minimal extraneous talk is used to ensure uniform responses which can be quantified.

Theoretical Sampling

Theoretical sampling is the process of data collection for generating theory. The analyst jointly collects, codes and analyzes the data and decides what data to collect next and where to find it. This is done in order to develop the theory as it emerges. This process of data collection is controlled by the emerging theory. The general procedure of theoretical sampling is to elicit codes from raw data from the start of data collection through the constant comparative analysis. The codes are then used to direct further data collection in order to gain saturation of the categories. This involves further interviews and re-interviews.

The "secondary sampling" technique is compatible with theoretical sampling. It is used to confirm hunches about the developing theory. Information is sought from additional participants. The finding is described to a person who has not been previously interviewed, thus: "Some people tell me that _____, is this true for you?" (Morse, 1989, p. 117).

The logic of theoretical sampling includes inductive reasoning; a theory is induced from the collected data. Deductive reasoning in grounded theory is used to derive conceptual guides from induced codes. This influences where to go next in data collection and analysis to generate theory.

In the collection of data, or theoretical sampling, the issue of saturation of emerging codes arises. Data is coded as the researcher proceeds so that not too much data is collected (Glaser & Strauss, 1967). Theoretical saturation of a category occurs when no new properties emerge in coding and analyzing. In

addition, the same properties emerge as one goes through the full extent of the data (Glaser, 1978). "Saturation often occurs after the analysis of five to ten protocols" (Rennie, Phillips & Quartaro, 1988, p. 143). The system of selecting "negative cases" (Glaser & Strauss, 1967, p. 138) is used to elicit variation and is considered by qualitative researchers to be a rational and valid method for identifying variation (Morse, 1989). An example of a negative case is an informant who does not fit the theory exactly, but instead adds new properties. Also, the negative case can be seen as seeking a person whose experience may be different from a theory that has been developed to an advanced stage.

The constant comparative method is the process in which the researcher compares incident to incident within and between interviews. The purpose is to establish underlining uniformity of incidents across the data which becomes the generated concepts and hypotheses. The researcher then compares the concepts to more incidents generating new theoretical properties of the concepts and more hypotheses. More theoretical sampling may be needed as the process of this open coding unfolds. Densification of these concepts by developing their properties occurs in addition to the generation of further concepts. Then the researcher compares concept to concept with the purpose of establishing the best fit of many choices of concepts to the data. Finally, the ordering of concepts is developed into a logical progression that outlines the topic being studied. Achieved is the purpose of saturation whereby theoretical elaboration and verification of the concepts is produced.

Considerations in Grounded Theory

The question. One consideration is the question of the study. The researcher may begin with virtually no question in mind, a clear question in mind or a general perspective (Glaser, 1978). Also, there may be a supply of beginning concepts and field research strategies. This is less than being completely open but still receptive to the emergent aspects of the data. It is very important to have as few predetermined ideas as possible as the mandate is to remain open to what is actually happening. This notion explains Glaser and Strauss's (1967) suggestion to not read literature in the area under study so as to not contaminate one's effort to generate concepts from the data with preconceived concepts that may not really fit, work or be relevant.

Grounded theory has four basic characteristics that are pertinent because it is generated systematically from research data. They are fit, work, relevance and modifiability.

Fit. By fit, categories of the theory must fit the data. Data is not forced or selected to fit pre-conceived or pre-existent categories. Another property of fit is refit. As categories emerge so quickly, it is important to constantly refit them to the data to ensure that they do fit all the data they purport to indicate. The researcher should readily modify categories as successive data may demand. The goal is to ground the fit of categories from the data as closely as possible.

Work. By work, the theory should be able to explain what happened and predict what will happen. This is achieved by getting the facts of what is going on by systematic research (Glaser, 1978). In order for the theory to work, the categories

must fit the data. Also, the theory must address the main theme of what is going on in the process being studied.

Relevance. Grounded theory attempts to arrive at relevance, by allowing the core processes to emerge from the data. In aid of the effort to arrive at the core category, Strauss and Glaser (1967) have developed the notion of Basic Social Process (BSP), for example, how a person becomes alcoholic. A BSP explains a large portion of the action in an area and relates to most categories of lesser weight conceptualizing the theory. Therefore, BSP's are integrative of all categories needed in the theory. This will be discussed further under core category.

Modifiability. Modifiability refers to the need of the theory to be modified as the data reveal themselves. However, the BSP will remain stable even though other concepts may change, depending upon other interpretations.

As the researcher collects and analyzes data these four criteria are always kept in mind. There is only discovery of what categories and their inter-relations fit and work best. Since there are no pre-determined hypotheses, an openness to correction and change must be accommodated at all stages of the research.

Analysis of Data in Grounded Theory

In the analysis of data a number of factors must be examined such as substantive coding, theoretical coding, memos, core category, reliability and validity. In order to generate conceptual codes the researcher uses insight. Generation of conceptual codes is achieved by a process of reducing data to appropriate categories of meaning.

Substantive Coding

Glaser (1978) discussed five rules for substantive coding which can be used as guidelines. The first rule is to ask a set of questions of the data. The questions are, "What are the data a study of? What category does this incident indicate? What is actually happening in the data?" (Glaser, 1978, p. 57). These three questions help the researcher to focus on patterns among incidents which yield codes that help to conceptualize the reported experiences.

The second rule is to analyze the data line by line, coding each sentence. This is painstaking, but is necessary for achieving a full theoretical coverage. The third rule is to interrupt coding to memo any ideas about concepts emerging from the data. The fourth rule is to stay within the substantive area, in this case bulimia nervosa. Finally, rule five is to never assume the analytic relevance of any variable such as age, sex, social class, race, skin color, until it emerges as relevant to the generated theory. Glaser and Strauss (1967) have found these variables to be of minor importance in studies of process such as becoming an alcoholic. These variables are used more as a description to orient readers regarding where and to whom the process may occur.

In substantive coding, the researcher determines what is indicated by the data. For instance, the researcher asks if data suggest a substantive code or a property of a substantive code. As the theory becomes more and more formulated, it becomes easier to determine codes and properties.

Theoretical Coding

Theoretical coding conceptualizes how the substantive codes may relate to each other as hypotheses to be integrated into theory. Glaser (1978) suggested eighteen coding families from which to draw theoretical codes. Researchers are also encouraged to develop their own coding families, and not be trapped into writing about others' codes. An example of a coding family is process. When a researcher refers to process there must be at least two stages. Processing refers to getting something done over time. The descriptive words indicated in the process family are: "stages, staging, phases, phasings, progression, passages, gradations, transitions, steps, ranks, careers, orderings, trajectories, chains, sequencings, temporaling, shaping and cycling" (Glaser, 1978, p. 74). Examples of the other coding families are degree, dimension, type, strategy, interactive, cutting point, means-goal, cultural, consensus, mainline, and unit family.

Memos

Memos are ideas obtained through the constant comparative method. Memos are ideas about codes. The consequences from memoing involve; forcing the researcher to think and reason through categories, undoing preconceived hypotheses, providing a source of direction for theoretical sampling and an opening to new possibilities. Memos are useful for obtaining insight into tacit, guiding assumptions (Rennie, Phillips & Quartaro, 1988). Memos are ideas about any aspect of the study. An important rule is to stop at anytime when an idea emerges and memo. Memos, rather than

indicators from the data, explicitly contribute to the construction of theory (Glaser, 1978).

Core Category

The goal of grounded theory is in the generation of a theory accounting for a pattern of behavior which is relevant to the topic being studied. The pattern of behavior is called the core category. The theory accounts for the core category. Only variables related to the core are used in the theory. The related categories and their properties make the theory subject to much qualification and modification. The core category has the prime function of integrating the theory and rendering it dense and saturated as the relationships increase (Glaser, 1978).

The core category is chosen by its explanatory power, and is related to as many other categories and their properties as possible. It accounts for a large portion of variability in a pattern of behaviors. It reoccurs frequently and is seen as a stable pattern. The core category in a substantive theory has clear and noteworthy implications for formal theory. It is also completely variable because frequent relations to other categories makes it highly dependently variable in degree, dimension and type (Glaser, 1978).

When the study is one of process, such as recovering from bulimia nervosa, then the core category is called a Basic Social Process (BSP). BSPs involve social processes. A BSP may involve psychological processes. When this is the case, the BSP becomes a Basic Psychological Process or BPP. Sometimes the BSP involves psychological as well as social variables. The BSP becomes a

Basic "Psychosocial" Process or BPSP. In order to be called a process, there must be at minimum two clear emergent stages. These stages should differentiate and account for variations in the behavior under study. The stages of the process function as an integrating scheme with which to tie together various sets of conditions and properties (Glaser, 1978).

Other defining properties of BSP's are pervasiveness and full variability. Pervasiveness refers to a patterned process in the organization of a behavior which occurs over time and progresses irrespective of the conditional variation of place. The basic substantive patterns of process cannot be altered. Codes can only be applied which best illuminate variations in what is going on. For example, "becoming" is basic, occurs over time and remains becoming no matter where it occurs and irrespective of how it is varied by current conditions (Glaser, 1978, p. 100). Full variability refers to the abstract quality of BSP's in that it varies sufficiently to apply in very different conditions.

Formulating the Theory

The final steps involve sorting the memos in order to formulate the theory for writing. Most researchers stop the study due to time, money and theoretical completeness. Theoretical completeness implies that the researcher explains with the fewest possible concepts and with the greatest scope, as much variation as possible in the behavior under study (Glaser, 1978).

In grounded theory, statements such as memos can become hypotheses. These are claimed as suggestions, not facts. Grounded theory is to be read as hypothetical suggestions, not as

factual description. Glaser and Strauss (1967) state that the theory is an ever-developing entity, not a perfected product. There are four criteria for determining whether a researcher has developed a grounded theory. It should be believable; that is, it is a plausible explanation to the reader. It should be adequate in that it does not omit large or important portions of the data. It should be grounded, thereby tied inductively to the data. Finally, it should be applicable, leading to further hypotheses and investigations (Glaser, 1978 and Rennie, Phillips & Quartaro, 1988).

The benefits of grounded theory begin with its contribution to people knowledgeable in the field of study. "What the man in the know does not want is to be told what he already knows. What he wants is to be told how to handle what he knows with some increment of control and understanding of his area of action". (Glaser, 1978, p. 13). Glaser (1978) often hears comments such as "That's the way it is. That's right" when presenting a grounded substantive theory to knowledgeable people (p. 13).

Another benefit is its full variability. That is, the substantive theory accounts for variation in the substantive unit being studied so that it can be applicable to all members of that unit. Also, it can be generalizable to other units involving similar experiences with some modification (Glaser, 1978).

Reliability and Validity

Certain methodological issues differ for quantitative and qualitative research. The issues are predetermined methodology versus emergent design, and differences in the role of the

researcher and role of the participant. These issues result in concerns of trustworthiness, to be addressed later.

Quantitative methods, typically experimental designs, insist that data collection be described in advance and prohibit any change once the study is under way (Guba, 1981). Qualitative designs, such as grounded theory, insist on an emergent design which is never complete until the inquiry is terminated (Glaser, 1978).

Role of the researcher. In grounded theory, the role of the researcher is highly involved and, therefore, should be explicitly outlined (Rosenthal, 1986 and Giorgi, 1970). Applying the emergent principle of grounded theory, the researcher develops a version of analysis based upon personal interpretation of the data. A researcher may, for example, stop analysis at the level of category description and report one category. Another researcher at a similar point may report a theoretical process or processes.

It has been written that the researcher's role in quantitative research is not always objective (Giorgi, 1970). For example, the quantitative researcher chooses questions or hypotheses, methods and the data analyses. The researcher is involved in the interpretation, discussion, and implication of results. Finally, interpretation of data is influenced by researcher bias and expectancy (Rosenthal, 1986).

In qualitative research, it is suggested that the involvement of the researcher be made explicit in order to better understand how the data are organized and interpreted. In qualitative research, for example, the researcher is seen as

engaged rather than detached (Giorgi, 1970). Thus, an accurate description of the process used by the researcher to achieve the purpose of the study must be used (Giorgi, 1970). Keeping a journal of the researcher's process and having it audited (Guba, 1981) assists in this process. Presuppositions may also be documented before collecting data (see Issues of Bias-Identifying Presuppositions, pages 66-68).

Role of the participant. In qualitative research, participants are included in several ways. First, they are seen as a very important influence in the direction in which the data collection proceeds. In grounded theory it is important to report as faithfully as possible, the actual experience of the subjects so that it can be clearly conceptualized. The discovery of the actual experience of the subjects is achieved by means of detailed description (Glaser, 1978 and Giorgi, 1970). Second, their feedback may be used to check data analysis during the research and before the final closure of the paper (Giorgi, 1970; Guba, 1981; and Kus, 1986). This procedure is called "member checks" (Guba, 1981, p. 85). Third, their feedback may be used to determine if the researcher acted in a "human way" (Giorgi, 1970, p. 45 and Pennington, 1981, p. 52). Finally, participants may be used as a validation check by asking them what they saw as the purpose of the study (Pennington, 1981).

Methodological issues of grounded theory. Due to the important role of the researcher in using the constant comparative method and adopting grounded theory to suit the researcher's needs and the role of the participant, issues of trustworthiness arise.

Trustworthiness. Guba (1981) proposes that there are four aspects of trustworthiness that should be addressed in all types of research. These aspects are addressed by different terms in qualitative and quantitative research. The four qualitative aspects are truth value, applicability, consistency and neutrality. Translated into their quantitative counterparts, they are internal validity, external validity, reliability and objectivity.

In establishing truth value, qualitative studies need to address the testing of credibility. In regards to applicability, the researcher addresses the testing of transferability. For the establishment of consistency, dependability is tested. Finally, in regards to neutrality the researcher needs to address the testing of confirmability.

Truth value refers to establishing confidence in the truth of the findings of an inquiry for the informants. Concern is with testing the credibility of findings and interpretations with the various persons from which data were drawn. Credibility is established by doing "member checks" whereby the data is tested with members of the source group (Guba, 1981, p. 85). Also, the theory may be read by people with similar traits who were not in the study (Kus, 1986). "Peer debriefing" with peers and members of the dissertation committee is recommended (Guba, 1981, p. 85), discussion with persons who are familiar with the method of grounded theory (Chenitz & Swanson, 1986).

Applicability refers to establishing the degree to which the findings of the inquiry may have applicability in other contexts or with other subjects. Interest is in the probable

transferability between two contexts which may occur because of certain essential similarities. Transferability is achieved by knowing a great deal about the context pertaining to the study and this is called collecting thick description (Guba, 1981, p. 86). This criterion is also referred to as fittingness (Glaser, 1978 and Chenitz & Swanson, 1986).

Consistency refers to determining whether the findings of the inquiry would be consistently repeated if it were replicated with the same or similar informants. Consistency is interpreted as dependability. The focus is on the trackability required by explainable changes in instrumentation. Dependability is achieved by keeping an "audit trail" (Guba, 1981, p. 87). An external auditor examines the notes and interpretations commenting on the degree to which procedures used fall within generally accepted methodology.

Neutrality refers to the establishment of the degree to which the findings of an inquiry are a function of the informants and conditions of the inquiry and not of the biases, motivations and interests of the researcher. Knowing the role that predispositions can play when the researcher acts as an instrument, confirmability must be established. This is achieved by keeping an audit trail, recording the methods and grounds of the insights of the researcher (Guba, 1981, p. 87). Giorgi (1970) recommended an accurate description of the researcher's process. An auditor examines the audit trail in relation to the product. This is called a "confirmability audit" and is used to certify that data existed in support of interpretations (Guba, 1981, p. 88).

Another aspect of validity that can be used in qualitative studies where persons are interviewed, is consensual validation. It is defined as "the determination that something is real, not illusory, by the fact of agreement between the perceiving of several persons" (English & English, 1958, p. 113). In ascertaining consensual validation in regards to persons answering the question of the study, the researcher determines if the participants agree on their understanding of the purpose of the study (Pennington, 1981). The researcher can ascertain that persons answered the question of the study. In ascertaining consensual validity in regards to the interviewer being present in a human way (Giorgi, 1970), it must be determined how the participants felt or thought about the interviewer.

> The human way in which the researcher is present can de facto be described by both himself and by the subjects, and the meanings that emerge from these descriptions represent the control, or set the limits for understanding other data that may have been obtained. (Giorgi, 1970, p. 131).

If the interviewer was neutral or withdrawn, perhaps the participants would be influenced in a negative way (Pennington, 1981). Thus, it can be determined whether or not the researcher was seen as acting in a positive, supportive, non-directive manner.

Issues of Bias - Identifying Presuppositions

The issues of investigator bias are a concern in all research. The researcher's bias will usually affect the choice of

research designs and procedures in such a way as to increase the likelihood that expectations or hypotheses will be supported (Rosenthal, 1986). In regards to grounded theory, the focus is not to prove anything, but only to present findings as hypotheses. In addition, a goal of grounded theory is to begin research with no preconceived hypotheses and allow the theory to emerge inductively from the data (Glaser, 1978).

The methodological orientation of the researcher raises questions concerning how during sampling the emerging theoretical sensitivity can be reconciled with theoretical biases and premises of the individual analyst. Glaser (1978) wrote that generally the background experiences of one's education and training are used formulating guidelines and reference points. The researcher uses these to deductively formulate questions, which may then elicit the data that lead to inductive concepts being formulated later.

One of the characteristics of the core variable and Basic Social Process (BSP) is a freedom from perspective. BSP's occur and continue irrespective of the bias of the researcher: "Purging is always purging, becoming is always becoming, no matter how perspective the rendition". (Glaser, 1978, p. 110). Different analysts will most probably emphasize different aspects of data; however, this bears more on scope than on credibility of an emerging theory (Rennie, Phillips & Quartaro, 1988).

In addition, Giorgi (1970) suggested that if the influence of the researcher cannot be kept out then it would be preferable for the researcher to be put in completely, in a way that reflects one's involvement with the world:

> "The major protection against bias is for the viewpoint itself to be made explicit, so that its validity may be circumscribed ... Precisely because man is always in a limited situation, in a perspective, we feel that an engaged attitude which acknowledges such a perspective is a more accurate description than an objective one, and thus we feel that a more accurate understanding of why research situations have validity may be achieved" (p. 189).

Thus, in doing qualitative research, it is important to document all presuppositions prior to the study (Giorgi, 1970). Preconceptions about the phenomenon under investigation need to be delineated when using grounded theory (Rennie, Phillips & Quartaro, 1988). This is an important process of research so that readers are more able to evaluate the theory.

CHAPTER III - METHODOLOGY

This section is comprised of the topics: preparation to implement the study, implementation of the study, criteria for assessing trustworthiness, ethical considerations, limitations and delimitations and the researcher's presuppositions.

Preparation to Implement the Study

An interview schedule was designed in accordance with the unstructured formal interview format. The interview schedule was comprised of the purpose and procedures of the study that provided information to participants, a consent form, a questionnaire of demographic data and the interview questions. In designing the interview schedule, three factors were considered. First, was the content of the interview questions. Second, was creating an atmosphere comfortable to both the participant and interviewer. Third, was using the pilot study as a means to assess the appropriateness of the interview content and process.

Content of Interview Questions

The ideas for the content of the interview came from the researcher's knowledge and experience of clients with bulimia nervosa. Questions were generated that explored psychological, social and physical factors, and intervention strategies that participants experienced in recovery from bulimia nervosa. The questions used in the early part of the study were modified by the researcher as she gained greater understanding of the experiences of recovery of the participants.

Creating a Comfortable Atmosphere

The intention of creating a comfortable atmosphere was to enable the participants to feel enough freedom and trust to discuss their experience of recovery. When the interviews were being arranged, the participants were asked where they would like the interview to take place, for example, in their home or in the researcher's office. Giving the participants the choice permitted the beginning of a trusting and comfortable atmosphere. To aid in creating a comfortable environment, open-ended questions designed to elicit a free flow of information from the participants were used. Supportive and empathic responses by the interviewer were used to encourage elaboration and clarification of relevant information. Due to the secretive and emotionally charged complexion of bulimia nervosa, the interviewer selectively disclosed relevant aspects of her own difficulties with disordered eating to model the process of sharing. This was done when seen as appropriate during the interview to provide further support to the participants.

Use of the Pilot Study

A pilot study was conducted to refine the interview process and the interview schedule. The pilot study occurred in the summer of 1989. The researcher was living in Vancouver at the time and placed a small advertisement under the persons wanted section in one of the newspapers. Five women answered the ad. The participant was chosen from the five because she had received treatment and she seemed like an appropriate subject. She was a single woman aged 27 who worked in public relations and

advertising. She had no history of anorexia nervosa, obesity or drug and alcohol abuse. Her bulimia began during the summer of her twenty-third birthday as a means of controlling her weight. The participant was bulimic for 4 years. After she had recovered for six months, she had a very mild relapse for a four month period. She then regained a state of recovery for four months. Even though she considered herself recovered, she did not fully understand the cyclical nature of the recovery process of relapsing and regaining control. She does not meet the standard used for the main study. However, she was a useful subject for the pilot study. The interview took place in the researcher's office in August, 1989.

The participant told the story of her recovery process. She had received 3 sessions from a psychiatrist and found them to be very helpful. During the interview, she was asked all of the questions contained in the interview guideline. The interview lasted for ninety minutes and was audiotaped.

The data were analyzed using the constant comparative method. They were analyzed initially by meaning units. Substantive codes and properties were developed. The substantive codes were: realizing problem, getting help, breaking binge-purge cycle, learning to abstain, cyclical abstinence, recovery and relapse. An initial core variable of personal resolve emerged in the exploratory analysis of the pilot study data.

Certain aspects of the interview schedule were changed as a result of the pilot study. For example, a description of the interview process was added for use of other researchers (see Appendix A). A section entitled "Purpose and Procedures of the

Study" was used to inform the participants of the nature of the study was included (see Appendix B).

A consent form to be signed by the participant was added following the pilot study (see Appendix C). Outlined were issues such as participant withdrawal and confidentiality.

A questionnaire that included demographic variables such as age, sex, occupation, marital status, age of onset of bulimia nervosa, income level, level of education and ethnic origin, was developed to provide descriptive information relevant to understanding the sample (see Appendix D).

For the pilot study, the interview questions began with general questions regarding factual information. These were used to allow the participant to begin discussing aspects of her bulimia that were mildly emotionally charged. These did not receive any changes. Some questions were omitted and others reworded following the pilot study. In the main study, 4 questions and 9 probes were used to explore the issue of recovery from bulimia. The questions were considered as a guideline for interviewing (see Appendix E). Finally, questions for consensual validity were utilized in both the pilot and main study.

Implementation of the Study

Sample Criteria

Several criteria for choosing recovered bulimics were used. First, the persons' past bulimia met standards of DSM-IIIR (1986). Second, they were recovered for one year or more. Third, the participants saw themselves recovered with occasional binges, such

as once per month. Fourth, they had not experienced anorexia nervosa, obesity, or drug and alcohol abuse. Fifth, some participants had received formal interventions and others informal interventions. Last, men or women would have been appropriate participants.

Sample Selection

Theoretical sampling using the constant comparative method was used to select participants. Volunteer sampling was used for recruitment by the use of newspaper articles. The first article was published on January 23, 1990. Twenty-four people responded. Five of the persons fit the criteria for the study. A second article was published on February 21, 1990. Twelve persons responded and five of them met the criteria for the study. Out of the total of 36 respondents, 10 constituted a potential sample. The remaining 26 were anorexic and bulimic (3), had abused alcohol (3), had abused alcohol and drugs (7), were obese (4), were recovered less than one year (2), were not recovered (4) and finally, were not bulimic (3). These 26 persons were not selected as they did not meet the criteria for the study.

Respondents to the newspaper articles phoned the newspaper secretary who then gave the researcher the names and phone numbers. These people were contacted. The 10 who fit the criteria for bulimia were asked questions about the duration of their bulimia, their age, when the bulimia began and whether or not they received formal treatment. Nine of these respondents were women and one was a man. Finally, the composition of the sample was controlled by primary and secondary selection

procedures. This meant that the researcher controlled who was selected initially by telephone and then during the interview, it could be stopped or information obtained could be omitted from data analysis. No interview was stopped and no information was omitted.

As the study progressed, the participants from the sample of ten were asked more specific questions about the process of recovery. In total seven women were interviewed. By the sixth interview no new categories emerged. A seventh interview was carried out in order to ensure that the data were rich and varied. In the early stages of theory development, negative cases were used to sample minor variations of properties emerging in the theory. Later, as the theory became more developed, negative cases that exemplified further variations were chosen.

Description of the Sample

All seven women were Caucasian. Their past bulimia met DSM-IIIR (1986) criteria. None of the women experienced anorexia, obesity or drug and alcohol abuse. The women deemed themselves recovered and reported no occasional bingeing. They all said that they overate occasionally as a normal person would do, for example at a Sunday dinner. All but one had been recovered for one year or more. The third participant had been recovered for eleven months at the time of the interview. This was a slight modification of the criterion of being recovered for a year or more. The woman was selected because she was a "good informant".

Three participants experienced formal treatment and informal treatment factors. Two participants experienced informal

treatment factors and one appointment with a medical doctor. Two participants experienced only informal treatment factors. Table 1 contains the participant characteristics such as age, age of onset of bulimia, number of years for recovery, number of years recovered, formal treatment and informal treatment factors. Participant 5 did not have a number for years of recovery because she never consciously began recovery. Included is a summary of the participants' stories (see Appendix F).

The Setting

The interviews for the study took place at the participants' homes. One interview occurred over the telephone because the participant did not want to involve her husband. Also, she had a two-week old baby and did not want to leave her home. All of the women chose the location for their interview. They had the option to meet with the researcher at her office.

Procedures

After initial instructions each informant was asked to read the "Purpose and Procedures of the Study" (see Appendix B). This was read to participant six over the phone. Each was then asked to read and sign the Consent Form (see Appendix C). It was mailed and returned by the sixth informant. The participants filled out the demographic questionnaire (see Appendix D). This process is outlined in the interview schedule (see Appendix A).

PARTICIPANT NUMBER	AGE	AGE OF ONSET OF BULIMIA	NUMBER OF YEARS OF BULIMIA	NUMBER OF YEARS FOR RECOVERY	NUMBER OF YEARS RECOVERED	FORMAL TREATMENT	INFORMAL FACTORS
1	34	24	4.5	.5	5	One app't with her M.D.	-Church -God
2	31	23	5	2	2	Psychologist individual sessions for 6 months	-Friends -Getting active -Leaving boyfriend
3	29	22	6	3	11 months	Psychiatrist individual and group sessions for 3 years	-Another job -Friends -Assertiveness training -Leaving husband
4	27	24	2	1	2	One app't with her M.D.	-Alanon -Friends
5	27	16	9	---	2	---	-Job -Apartment -Friends -Her life settling down generally
6	29	20	4	4	1	Psychologist individual sessions for 6 months	-Change in career -Her life coming together generally
7	33	18	13	.75	1.25	---	-Pregnancy

TABLE 1 - PARTICIPANT CHARACTERISTICS

Interview

The interviews were audiotaped. Three general questions of factual information were asked, leading up to the actual interview questions. Throughout the interview, the researcher attempted to remain sensitive to the comfort of the participant. Besides some initial discomfort with the recording procedures for two of the participants, the tone of all of the interviews was relaxed.

For the first two interviews, the researcher used the four interview questions and the probing questions as the guideline. However, by the third interview, the researcher allowed her experience and understanding of bulimia to guide the questioning. This was due to the researcher becoming more familiar with the process of recovery and to what information seemed relevant to the constant comparative method. Towards the end of the interview the informants were asked, a) what they had learned by recovering from bulimia nervosa, b) what kind of maintenance program they had if any, and c) what they felt was the purpose of the study and how they experienced the researcher. This process was carried out for the first five participants. The interviews were about 90 minutes, including the social visiting which occurred before and after the interview.

The fifth participant was chosen as a negative case because it seemed from the telephone interview that she did not just stop the bulimic behavior as the other four participants had reported. Her bulimia subsided gradually until it ended. In addition, the researcher had already interviewed four participants who had received formal treatment, two of whom had one appointment with

her medical doctor, and informal interventions. The fifth participant had experienced only informal interventions.

Follow-up interviews with participants two, three, four and five were conducted to clarify and expand issues raised in a meeting with committee members. Participant one could not be reached. Her telephone was no longer in service and she was not listed under information. The follow-up interviews were done by telephone and audiotaped. A third interview was conducted with participants three and five several days later. They were asked to expand on the question "What other factors helped you to recover, besides your motive to change?" The researcher prodded and encouraged the participants to delve inside themselves for possible responses.

The sixth participant was interviewed by telephone as she had requested. She was chosen as a negative case because she did not feel that telling someone about her bulimia was of great importance to her recovery. Her statement was similar to the fifth participant and both of these were different from participants two, three and four. These three persons said that telling was of great importance to their recovery process.

The researcher used the secondary sampling technique to explore the sixth participant's experience. For instance, the researcher said "some participants realized their behavior by either watching a television program or they got caught vomiting .... Does any of this relate to you?" During the second half of the interview, the researcher questioned the participant in a similar fashion of prodding and encouraging her to delve inside of herself for further information on recovery.

The seventh interview was carried out using the secondary sampling technique in order to further verify and saturate the categories. This participant was chosen as a negative case because she stopped her bulimia due to her pregnancy. All of the other participants had reported other motives.

In order to monitor the process of interviewing and prevent leading statements by the researcher, transcripts of the second interview were distributed to members of the dissertation committee and peer committee. Feedback was requested and the researcher's interviewing style modified accordingly.

Audit Trail

During the entire study, the researcher kept an extensive journal of the research process including a detailed audit trail. An audit trail was in the form of documentation of the actual interview transcript and a running account of the process in the form of the researcher's daily journal. This file was labelled "audit trail" specifically. Another file entitled "journal" contained all of the researcher's daily activities in relation to the research project such as library research, trips to the typist, books read and so on. Finally, a third file was created labelled "memos". This file contained ideas or memos on the developing categories and hypotheses during the research process. In addition, there were bi-monthly meetings with members of the dissertation committee and weekly meetings with a peer group conducting grounded theory research on other topics.

Process of Analysis

The coding procedure consisted of an ordering of general levels of recoding of information from a very descriptive to a generalized level of conceptualization. The first three interviews were analyzed line by line using invivo codes. This meant that the researcher used words from the informants' language for coding. For the next level of coding, the researcher used broader, more common descriptive terms, that captured the collective meanings of previous codes. This process continued until substantive codes were generated. The constant comparative method that explored common meanings between and within interviews was used at each stage of coding. A factfinder computer analysis program was used to organize data. Coding was organized so it could be accessed under several categories. For example, for a friend who was supportive in the recovery process, the datum was coded Friend - Support and Support - Friend. In this way, the factfinder could place pieces of data under many different categories. This aided the analysis of data by the constant comparative method.

After the second interview the writer began a secondary review of the literature on the process of change, motivation, addiction, bulimia and anorexia, using a computer for cross-referencing.

After analyzing the first three interviews as described, the fourth interview was then done. The interview was recorded, transcribed and analyzed. All four interviews were then recoded using the constant comparative method. Codes became more refined,

precise and uniform across all four interviews. This level of coding was called substantive coding.

The next step was to organize all of the codes across the four interviews into groups. The fact finder program organized all of the codes into alphabetical order for each interview. Using the constant comparative method, new codes across all participants were generated to develop the concepts that accounted for the theoretical framework that emerged from the overall information to date.

The substantive codes were linked together in hypothetical groups and stages became apparent. After three codings, a theory emerged with clear stages. The fifth participant was then interviewed. The analysis of this interview began with invivo codes and very soon went to the substantive level of coding used for interviews one to four. The researcher added the data to the emerging theory which had developed into a 4 stage theory, comprising contemplation, action, recovery and maintenance. The only new information added was another dimension to how bulimia stopped. Stopping as incorporating a temporal fact such as sudden or gradual change became evident. At this point, a core variable entitled "personal resolve" was being considered by the researcher. However, further analysis of the overall picture of the data was needed to confirm the validity of this basic social process. A meeting with the auditor took place in order to examine the audit trail and the general progress of the study. The auditor was an experienced person in the analysis of psychological data from a mathematical and interactionist model (see Appendix G).

Follow-up interviews to clarify and expand emerging concepts were conducted. It was found that the order in which the telling occurred was different. Participants two, three, and four told someone about their bulimia and then acted. Participants five and six acted and then told someone about their bulimia. From the expanded interviews the concept of personal resolve seemed to be an inadequate concept for the BSP. A new core variable was considered.

The seventh participant, who stopped her bulimia because she was pregnant, was interviewed as a negative case. No new categories or properties were found.

Intense deliberations about the overall patterns in the data were conducted searching for the emergence of the core variable. From this investigation, the most important factors that accounted for recovery emerged as "opening the self". This was considered to be the basic psychosocial process. Further meetings with the committee and peer group members helped to consolidate that "opening the self" was the core variable.

Establishing Trustworthiness

Criteria for Evaluating a Substantive Theory

Four criteria were used to evaluate the substantive theory in order to determine whether or not the theory was grounded. As discussed in the literature review, the criteria include the theory being believable, adequate, grounded and applicable. In determining the theory being believable, a mental health worker read the theory. Adequacy was established by the auditor. The

theory being grounded was ascertained from member checks. Applicability was determined by developing further research ideas.

Criteria for Assessing Trustworthiness

The four aspects of trustworthiness addressed in this study were truth value, applicability, consistency and neutrality. In establishing truth value, credibility was determined by member checks using secondary sampling with participants to verify the analysis of data and peer debriefing with members of the dissertation committee and a peer group committee. After the study was completed, member checks were again utilized before the final draft was written. In addition, the theory was read by two persons with similar eating disorder traits as the participants in the study. In determining applicability, transferability was established by collecting thick descriptive data such as age, sex, occupation, marital status, income level, level of education, ethnic origin, age of onset of bulimia, number of years of bulimia, length of recovery, number of years recovered, treatment factors, and informal treatment factors. In determining consistency, dependability was established by the researcher developing an audit trail during the steps of analysis. The external auditor examined in depth the researcher's audit trail. In determining neutrality, confirmability was established by keeping a journal on the assumptions used in analyzing the data. After the study a "confirmability audit" by the external auditor was used to determine that data existed in support of interpretations generated by the researcher.

Consensual validation, another aspect of validity was used to establish trustworthiness. Two questions were used to determine if participants were in agreement on their view on the purpose of the study and how the researcher acted during interviewing. The questions were:

> What do you feel was the purpose of the interview?
>
> How did you experience me?

Usefulness of the Theory

It was important that the theory be useful and meaningful for people working in the field of the substantive area. The theory was given to a psychiatrist and to a therapist working with bulimics, to read and provide feedback.

Ethical Considerations

The proposed study was given clearance by the University of Alberta Educational Psychology ethics committee in December, 1989. The privacy of the participants was protected by reporting data without identifying information. All identifying information was removed from any material quoted from interviews to protect confidentiality. The audio-recordings were erased after being transcribed due to the expensive nature of the recording. The transcriptions were kept safely by the researcher for the duration of the study.

Participation in this study was voluntary. The study was explained to the volunteers. The participants were informed that they could withdraw from the study at any time (see Purpose and

Procedures of the study, Appendix C). The results were shared with any participant who requested them.

The researcher was a chartered psychologist trained in interviewing and counselling people about their personal difficulties. She had been working part-time during her graduate studies. It was recognized as important to keep roles of researcher and counsellor separate for the duration of the study. The researcher was prepared to refer participants to counselling services, if necessary, however, this did not occur.

Limitations

A first limitation was involving only females in the study. Although males have been reported as having bulimia none were incorporated in the interviewing. A second limitation was choosing only verbal persons. A third limitation was using only volunteer participants. A fourth limitation was choosing only individuals from newspaper readers. These people may be more educated than non-newspaper readers. A fifth limitation involved the small number of people studied in the research. A sixth limitation was studying only one woman who recovered from bulimia due to pregnancy. This may have influenced the results. A seventh limitation was that the definition of recovered may not incorporate information that would be garnered from people who have been recovered for longer periods of time. Finally, the eighth limitation was that the participants in the study were chosen from the city of Edmonton. Thus generalizing to all bulimics was limited.

Delimitations

The first delimitation to the study was the criteria of the sample. Only persons with bulimia were chosen and not those with anorexia or drug and alcohol problems. The second delimitation was interviewing persons who had recovered from bulimia and not those at other stages of the recovery process. The third delimitation was using the interviewing procedure and not other procedures such as observation in a natural setting. The fourth delimitation was interviewing actual recovered bulimics and not family members. Finally, the fifth delimitation was using the qualitative design of grounded theory.

Researcher's Presuppositions

The researcher documented her presuppositions. The theoretical codes and conceptual categories from the pilot study were considered as part of the researcher's presuppositions. The theoretical codes which emerged from the pilot study were stage, motive, temporal ordering, accumulated strength, critical juncture and strategies. The substantive codes were realizing problem, getting help, breaking binge-purge cycle, learning to abstain, cyclical abstinence, recovery and relapse. Also, personal resolve, considered as a core variable, became apparent. However, it was not documented in the pilot study.

Another presupposition was the researcher's belief that self-awareness would be a factor involved in the recovery process. The researcher's disordered eating improved as she became generally more aware of herself through personal growth groups. The researcher was aware, however that self-awareness may have

nothing to do with experiences seen as most significant by recovered bulimics.

Another presupposition was that some kind of internal change would be seen as significant in the process of recovery. From the researcher's experience, as she changed internally such as learning to accept and express feelings, her disordered eating subsided. However, it was acknowledged that a participant may report an external factor as being significant.

Based upon previous personal and counselling experience with bulimia nervosa and disordered eating, the next presupposition was the notion that individuals would intentionally recover. For instance, a bulimic seeks treatment or other strategies to intentionally recover. It may be that some participants recover without intention.

The final presupposition was based upon the researcher's experience of her binge diet patterns improving during the times of attending personal development groups, which were not focused on eating. A presupposition was that experiences that involve the whole person and not bulimia per se, could be directly beneficial to the recovery process.

CHAPTER IV - THEORY OVERVIEW

Basic Psychosocial Process: "Opening the Self"

The purpose of this study was to generate a substantive theory about the processes involved in recovering from bulimia nervosa as described by seven women. This overview of the theory developed from the data, introduces the basic psychosocial process (BPSP) which emerged as "opening the self". Opening the self was a basic psychosocial process (BPSP) because it involved a combination and interaction of psychological and social variables. It was a psychological process because it focused on the self, a psychological construct. Also, it was a social process because the self in this theory was influenced by social interaction, environmental factors, and individual interpretation and integration of information.

The analysis of the data suggested that the process of recovery involved an unfolding over time. For most of the women the process began when they realized that their behavior was not normal or healthy and they told someone about their behavior. They opened up and felt relief. The more they sought to be themselves and seek other ways of coping and living, the less bulimic they became. The women functioned better psychologically, emotionally and socially as they continued to recover. As they became involved with their lives, food and dieting were no longer the major focus. The women reported that they were less concerned with what others thought of them and more concerned with how they thought and felt themselves. In answer to the question about how others would view them now that they are recovered, they all

answered similarly, that they would be seen as happy. When the women described themselves as bulimic, they seemed to be closed and keeping their behavior a secret. Also, the bulimia was used to avoid themselves and others. It seemed that the bulimia was a matter of being too focused on avoiding the self. As they became more of who they were and opened to themselves, they became less and less bulimic. Therefore, the BPSP was called "opening the self".

The following section will describe the theoretical codes which emerged from the theory. Theoretical codes conceptualize how substantive codes relate to each other. Each code occurs throughout the theory in varying degrees (Glaser, 1978).

The Theoretical Codes

The following theoretical codes emerged from an analysis of the substantive codes. Theoretical coding was done as a preliminary step to discovering the core category or BSP. Some of the theoretical codes were taken from the suggested "coding families" (Glaser, 1978, p. 75). Other codes were developed by the researcher. Some of the theoretical codes were described in relation to substantive codes because without them, theoretical codes are empty abstractions (Glaser, 1978). In Chapter V, the theory is presented in terms of the substantive codes and indicators from the data. Substantive codes were related without reference to the theoretical codes, since the theoretical codes are always implicit (Glaser, 1978). The theoretical codes were opening, self, personal resolve, stages, temporal factor and cyclical pattern.

Opening

The definition of "open" according to Funk & Wagnall's Standard Dictionary (1980, p. 552-553) has many different meanings and implications that were applied to the various meanings of the theoretical code "opening" throughout theory of recovery from bulimia. The meanings of open were seen to capture the subtleties of "opening" that operated at the different stages and concepts of the theory of recovery. Over fifteen aspects of the definition of open seemed to apply. Some examples follow.

In the contemplation stage of "opening the self", the women realized they had bulimia and began to consider motives for changing. In order to look at one's behavior and consider change, the person needed to be receptive. The definitions of open that seemed to apply were "affording view; not settled or decided; pending and available". These definitions seemed to depict aspects of the self opening, in the women looking at themselves and contemplating change through consideration of motives.

In the action stage of "opening the self" the women took action by telling someone of their behavior. Then, some took formal treatment, others informal factors. As a result the bulimia subsided. In order to take action, the women seemed to become more open and prepared to do something about their behavior. The definitions of open which seemed applicable were "not secret or hidden; not deceptive". Also, some of the verbs in the definition of open related to taking action, for example "to remove the covering, lid; to bring into view; unroll; unfold; to reveal: to open one's heart and to begin, to start". These definitions seemed to describe processes in the action stage.

"Opening" of the self appeared not only as different meanings throughout the concepts of the theory of recovery from bulimia, but in different degrees. Opening was most evident throughout the stages of the recovery process. This will be addressed in Chapter V.

Self

Many authors (Orbach, 1984, Levenkron, 1982; Cauwels, 1983 and Pope & Hudson, 1984) wrote that bulimic behaviors usually begin as a purposeful act as a means of dealing with uncomfortable feelings and situations. Rather than facing the development and change in the self, a focus on controlling food consumption is substituted. In order to gain a semblance of control, obsession with eating and bingeing occurs. Thus a person "compensates" for growth in the situation by eating food (Lowen, 1981, p. 267) In giving up growth, the "self settles for a secondary integrity", by turning against itself, as a means of surviving (Perls, Hefferline & Goodman, 1951, p. 484). The self conquers itself, retroflecting the feelings and thoughts. As a result many aspects of the person become affected such as creativity, socialization and self growth to name only a few (Clarkson, 1989). The ego chooses to continue to regulate in this way, ending self-regulation (Van De Riet, Korb & Gorrell, 1980).

It appears that for the persons who recovered from bulimia nervosa, a critical event frequently happened, such as reaching a personal bottom point where the persons chose to change. The persons decided to act because of the necessity and readiness to change. This occurred because of an interaction of factors

involving the self and the outer world. The self is a very important factor in the process of change as one changes because one wants to (Stuckey & Glassner, 1985).

The Penguin Dictionary of Psychology (Reber, 1985) defines "self" in broad terms. Listed are six primary intentions of the term self. For the purpose of this research four of the intentions will be presented. First, the self is described as an inner agent or force with controlling and directing functions over motives, fears, needs. The self is an assumed aspect of the psyche with a particular role to play. This aspect of the self is referred to as the "me being the self known", the self as object. The second intention views the self as inner witness to events, the I being the knowing self, the self as subject. Here the self is seen as a component of the psyche which serves an introspective function. Presumably, this self can introspect upon the self as expressed in the first definition of intentions (above). The third intention views the self as the totality of personal experience and expression, the self as a living being. Other terms like ego, person, individual, organism, etc. are acceptable synonyms. The fourth intention describes the self as consciousness, awareness, or a personal conception. The self is seen as identity.

In relation to this research, all four aspects of the self seem applicable in some respect. For example, the self as an inner agent controlling motives, fears and needs applies to the women regulating the bulimia and moving into new directions of living. The self as a witness to itself is evident by the women realizing that they had a problem. The self referred to as a

living being is evident by the women's description of themselves as acting, choosing, knowing persons. Finally, the self as identity relates to the recovered bulimics describing themselves as healthy and inner-directed. The issue of self emerged continuously at all levels of the recovery process and is therefore seen as an important code in the conceptualization of the recovery process. This was supported in the interview data describing the recovery process from bulimia nervosa.

Personal Resolve

Another theoretical code emerged as personal resolve. According to the Funk & Wagnall's Standard Dictionary "personal" is defined as pertaining to the individual and "resolve" as "to decide or determine (to do something) . . . to make up one's mind; arrive at a decision; a fixity of purpose; resolution; a fixed determination; a resolution" (1980 p. 683). Personal resolve appears to be present throughout the process of recovery in varying degrees. For example, as the women realized they had a problem they decided to take action. The women then continued acting and gradually the bulimia subsided through the function of personal resolve. Even when they stopped the behavior, they continued to be determined to maintain recovery. Personal resolve is present in a lesser degree when the women forgot about their bulimia, for example, while they were at work. Personal resolve is most evident in the following sample statements from one of the participants,

"I had to move on . . . . I had to break myself of the habit . . . . I was going to do other things [to break the habit]

. . . . [I thought] I'm gonna have a good life, I'm going to be happy, I'm going to stop this, I'm going to put this part behind me" (Participant 6).

Stages

From the process family the theoretical code "stage" was chosen (Glaser, 1978, p. 79). Stages were treated as theoretical units in themselves comprised of substantive codes and properties. Stages were perceivable because they formed a sequence with one another. Stages allow the readers to follow changes yet remain cognizant of a process with a beginning and an end.

It was apparent that there were four stages in the recovery process from bulimia. They were:

Stage 1 Contemplation
Stage 2 Action
Stage 3 Recovered
Stage 4 Maintenance

Stages were sometimes clearly delineated. At other times the transitions from one stage to another were not clearly demarcated. This will be detailed in Chapter V.

Contemplation was understood by the definition of "contemplate" which is defined in Funk & Wagnall's Standard Dictionary as: "to look at attentively; gaze at; to consider thoughtfully, meditate upon; to intend or plan" (1980, p. 164). The term contemplation was chosen from the transtheoretical model of change (DiClemente & Prochaska, 1985). The term was found to be more fitting than any other and thus adopted (Glaser, 1978). Contemplation captured the entire sense of stage one. This stage

had two substantive codes, "realizing behavior" and "generating motivation", which helped participants contemplate change.

The action stage was comprised of two substantive codes, "taking action" and the bulimia "subsiding". Acting in some way in order to help the bulimia resulted in the bulimic behaviors subsiding.

The recovered stage was comprised of five substantive codes. They were "stopping, choosing health, knowing, relapsing and functioning better". Being recovered from bulimia meant that bingeing and purging had stopped, the women chose to be well, they knew they were recovered, relapsing sometimes occurred and all of the women functioned better in their lives generally.

The maintenance stage was comprised of three substantive codes, "eating, exercising and monitoring feelings". These codes addressed aspects that the women were conscious of, in maintaining their health.

Temporal Factor

Temporal factor was the next theoretical code and it implied that there was change over time with variation in the order of events. It seems that realizing that the bulimia was not normal and unhealthy led the women to act by telling someone about their behavior and then taking action through formal treatment and informal factors. Even for the women who told someone about their bulimia after taking action, there is change over time, with variation in the sequence of events. For instance, a participant realized she had a problem, she decided to take treatment and she told her psychologist. Her bulimia then began to subside. For

the woman who told her husband yet did not stop the bulimic behavior, she said "It certainly was a relief to talk to somebody about it, it took a load off, maybe it was part of the process" (Participant 7). This participant said that perhaps it was a combination of everything that helped her recover. It seems that in most cases, once the process of recovery began with realizing the problem, one thing led to another, which resulted in recovery.

Cyclical Pattern

The last theoretical code was cyclical pattern. "Cyclical" is defined in Funk & Wagnall's Standard Dictionary as "pertaining to or characterized by cycles", and "cycle" is defined as "A recurring period within which certain events occur in a definite sequence" (1980, p. 190). From the data, the notion of a cyclical pattern emerged where most of the women mentioned their bulimia subsiding gradually. Before the bulimia stopped, "[It] continued for a while after going into Alanon, but it slowed down." (Participant 4). When bingeing and purging occurred "I would try not to let it ruin my day . . . . [and] give myself positive reinforcement if I did it less frequently rather than not at all" (Participant 6).

It seems that the process of recovery was cyclical in that the women contemplated, acted, the bulimia subsided and then the women contemplated, acted, the bulimia subsided and the cycle repeated itself until, "The periods just became longer and longer in between" (Participant 6). Eventually the cycle of bulimia no longer continued and the bulimia stopped. For some of the women, a relapse occurred, a learning took place and the

bulimia stopped again. There was an exception reported by one of the women. Her bulimia was cyclical, for example, she said, "It went through phases of good and bad but never did I stop." However, her recovery process was not cyclical, because "After I found out I was pregnant . . . . I just quit" (Participant 7). All of the other women did report a cyclical characteristic to their recovery process. It seems that they took two steps forward and then one step back, then three steps forward and one step back and so on, until the bulimic behavior no longer occurred. Although the transition points varied for each person, there was a basic cyclical pattern.

In summary, this overview included an introduction to the basic psychosocial process of "opening the self" and a presentation of the theoretical codes. These codes were all present implicitly throughout the theory of recovery in varying degrees. An outline of the process of recovery from bulimia nervosa is presented in Table 2. The cyclical pattern of recovery is illustrated by the spiral in Figure 1.

Table 2
Theoretical and Substantive Codes

I Basic Psychosocial Process - Opening the Self

II Theoretical Codes
- Opening
- Self
- Personal Resolve
- Stages (4)
- Temporal Factor
- Cyclical Pattern

III Substantive Codes and Properties (according to the 4 stages)

1) Contemplation Stage
   i - Realizing Behavior
   ii - Generating Motivation

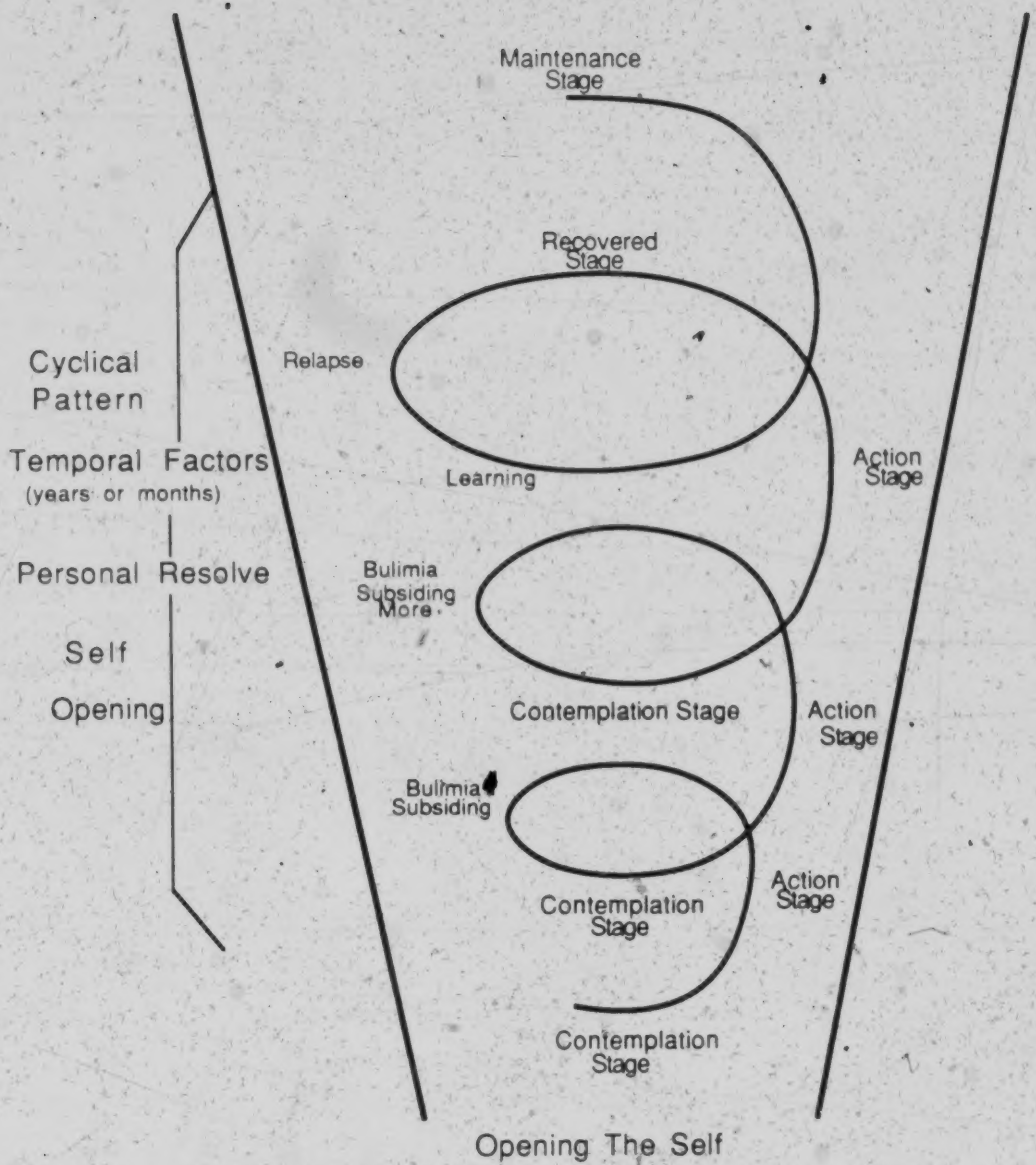
2) Action Stage
   i - Taking Action
   ii - Subsiding

3) Recovered Stage
   i - Stopping
   ii - Choosing Health
   iii - Knowing
   iv - Relapsing
   v - Functioning Better

4) Maintenance Stage
   i - Eating
   ii - Exercising
   iii - Monitoring Feelings

Figure 1.

The Process of Recovery
From Bulimia Nervosa



CHAPTER V

DESCRIPTION OF THE PROCESS OF OPENING THE SELF

The basic psychosocial process of the recovery from bulimia involved an opening of the self. Opening the self, at all stages of the recovery process seemed necessary in order for the women to recover from bulimia. People appeared to move through four stages in the recovery process. Stages functioned as an integrating scheme which tied together various sets of conditions and properties in a way that allowed for a high amount of densification and integration of data. The transition from one stage to another occurred at different times for different persons (Glaser, 1978).

The stages of the theory of recovery from bulimia were contemplation, action, recovered and maintenance. Contemplation was comprised of realizing the bulimic behavior and having some kind of motive to move into the second stage action. Action consisted of taking action of some kind which resulted in the bulimia subsiding. The third stage recovered, was comprised of stopping bulimia, choosing to be well, knowing that the bulimia is over and yet never over, relapsing and functioning better in general. The fourth stage was maintenance. This final stage consisted of a focus of healthy eating habits and exercise. In addition, some importance was given to dealing with feelings and other aspects of the self, such as negative thoughts. A description of the process of recovery, using indicators from the participant interviews follows.

Contemplation Stage

The first stage in the process of "opening the self" and recovering from bulimia was contemplation. Contemplation involved looking at the bulimic behavior and considering motives for changing. This stage was comprised of two substantive codes, realizing behavior and generating motivation.

Realizing Behavior

In order to realize they had a problem, the women had to open themselves and acknowledge that the eating behavior was unhealthy. All of the women realized that their behavior was unhealthy or abnormal. They reported three ways that contributed to the realization of their behavior. The three ways or properties were media, getting caught and intrinsic.

Media. Some of the participants realized their behavior from media such as television programs or articles.

> There would be something on T.V., I would listen to it for awhile and then I would shut it off, because I couldn't watch it anymore. It scared the hell out of me. (Participant 2)

> There was a movie that came on T.V. that had to do with bulimia. I sat and watched it and scared the living day lights out of myself, that was exactly what I was doing. I got really scared. (Participant 4)

> I didn't know it was anything until I started reading it in the papers, articles and started to be more aware that it

had a name. As I read more I became aware that it affected your health. So that scared me a bit. (Participant 7)

Getting caught. Some of the bulimics got caught, the second property of realizing the behavior.

> [My friend] was watching me eat lunch and often disappearing and going to the bathroom and getting sick . . . . Well, I was getting caught and I realized myself that there was something really wrong. (Participant 4)

> My mother had caught me and my boyfriend too. Everyone's attitude was to sweep it under the carpet and say just don't do it. (Participant 5)

Intrinsic. The third property of this category of realizing the behavior was a participant who realized intrinsically that her behavior was inappropriate. She had not read or heard anything about bulimia.

> [I] knew that it wasn't normal, that it was wrong. You see alot on T.V. now, but then I never saw anything. (Participant 6)

Variation. A variation of this category was a woman who realized her behavior but did not believe she was bulimic until after she had recovered.

> I used to read things and think that's not me, I'm not that bad. (Participant 5)

Generating Motivation

During the interviewing, the participants each disclosed significant thoughts that motivated them to begin the recovery from bulimia. Internal and external motives to recover appeared as the self opened.

Internal motives. Internal motives were not wanting to die, being tired of the lifestyle, and wanting to stop because it was not right.

> I just got tired of the toilet. (Participant 1)

> That's the thing I was most tired about, trying to hide it. I was getting tired of doing it . . . . I was just tired of all that. (Participant 3)

> Mostly [I wanted to stop] because I just didn't want to kick the bucket. I didn't want to die . . . . I didn't want to be sick anymore. (Participant 2)

> I knew that if I didn't stop this that I would kill myself . . . . I didn't want to be sick. (Participant 4)

External motives. Motives included external factors such as the spouse, children, being pregnant, and not coping with life. Although external factors have an internal reference, the stimulus for change originates outside of the person.

> My son was a big influence. He would come into the bathroom when I was purging. He would rub my back and say 'it's O.K. mommy'. I didn't want him growing up like that . . . . I wanted to be there for them and my husband. (Participant 4)

> I wanted to quit doing it for the sake of myself and my children . . . . I was robbing from them, times of enjoyment [by] using the money to go and buy whatever I wanted to pig out on and binge on. (Participant 1)

The woman who stopped because she was pregnant had not previously found another motive strong enough to make her stop.

> I had lots of reasons but they didn't seem to be strong enough . . . . my health . . . . [and] it was taking up so much of my time . . . . It dominated everything . . . . then I found out I was pregnant . . . . I just felt like if I did that it would harm the baby . . . . So . . . . I just quit. I guess it was that important to me. (Participant 7)

And, lastly

> It was making me very unhappy and it was making it difficult for me to cope with other things and I just wanted to change, to stop. (Participant 6)

Variation. A final variation of the substantive code was a woman who reported feeling no particular motive for stopping until later.

> It was no one thing that made me want to stop . . . . As things got better [in my life] it just didn't seem right anymore. I felt bad and ashamed of myself when I did it and then that made me want to change. (Participant 5)

Action Stage

The women seemed prepared at this point to enter into the action stage. This stage involved taking some kind of action in

order to help recovery from bulimia. As a result, the bulimia subsided. The action stage was comprised of two substantive codes with corresponding properties. The codes were taking action and subsiding.

Taking Action

In order for the women to take action of any kind, further opening of the self seemed to be necessary. Three kinds of action were reported by the participants, telling, formal treatment and informal factors. These were conceptualized as the three properties of taking action.

Telling. For the majority of the women, telling someone about the behavior was the first step of taking action. These women reported that they probably could not have recovered without telling someone about their behavior.

> No way, I tried a million times to quit on my own so I can't imagine being able to recover without having told [someone]. (Participant 3)

> No, because it is still a secret. As long as you're keeping it a secret inside you're not really admitting you have a problem and that you really have to do something about it. The telling was a real healing part. To me it was saying it's O.K. that I'm bulimic, I'm doing something about it. (Participant 4)

Variation. The variation to the importance of telling occurred for three women who told someone about their behavior later. They reported that the telling was not important for their

recovery process but that there were benefits from the opening and sharing.

> I don't think it really was [important] because by then I had made up my mind. It was just something I wanted to share with him. I felt relief that he knew about it, that it wasn't something I kept secret anymore. (Participant 5)

> The telling itself didn't make me stop. It certainly was a relief to talk to somebody about it - it took a load off. (Participant 7)

These women's accounts demonstrate a variation to the order of the properties of taking action in the action stage. Four of the respondents in this study told someone and then used formal or informal treatment factors to help themselves recover. The other three women used formal or informal treatment factors and then telling occurred later. Whether or not the persons told someone about the bulimia, they all reported taking some kind of action.

Formal treatment. The notion of the self opening and the person recovering from bulimia through formal treatment was evident. The women reported benefitting from treatment which seemed to imply a further opening of the self. For the women who took action by seeking formal treatment, almost all reported positive experiences.

> The therapist I had was really, really good, of course she helped start it all . . . . I think I had a lot of anger in me and I dealt with it in the therapy . . . . so that was the part that therapy helped, just dealing with my own feelings. (Participant 2)

> I went to group once a week and saw [a psychiatrist] once a week. I really think she helped me understand about that relationship I was in. [In group] I realized there were other people who felt exactly the way that I did, which of course was major. That was a big relief. (Participant 3)

Variation. Only one woman felt that her experience of formal treatment was not helpful. She had one appointment with a medical doctor.

> I went to a doctor to find out how he could help me and he gave me these diet pills which sent me flying so I quit taking them. (Participant 1)

The women who received formal treatment stated that other factors were significant in their recovery in addition to formal treatment.

> I had a lot of support [from friends]. [My roommate] was really supportive, really supportive . . . . And then another couple of friends was the big thing. (Participant 2)

> I [also] started going to assertiveness training class. That was about a year later and anti-depressants . . . . it's never one thing. (Participant 3)

Informal factors. For the women who did not seek formal treatment, they found other means of helping themselves. These informal interventions to helping themselves covered a number of approaches.

For me, it was God. After I came and accepted Him as my personal Saviour, I guess I cried out to Him and said if you are really there, you know, you have to help me with this and He did . . . . I promised the Lord that I would never do it again. (Participant 1)

I grabbed hold of the Alanon program, took a look at me, what my problems were. I faced alot of my past. I faced my fears. I was full of fear. I hated myself. (Participant 4)

Other informal interventions, which most of the women used, incorporated strategies to deal with bulimia.

I just had to stop being by myself so much and being in my house. I had to start doing other things; going out, staying out, going out eating with friends, doing something after. Not eating and saying gotta go, by . . . doing other things taking my bike, going to my mother's house or my friend's place, just a change in lifestyle. (Participant 2)

I just had to pick up the phone or go to somebody's house when I had the urge to purge; I had to stay away from that bathroom. (Participant 4)

Other woman focused on other aspects of their lives and without intentionally trying, recovered from bulimia.

I think once I started working and once my life seemed to settle down . . . . Things in my personal life as far as

. . . . my parents' divorce . . . . getting clear . . . . and living on my own and having a job [and] my relationships with [friends] sort of settled down,to the point where I didn't feel the need to do it anymore . . . . I guess I just felt a lot better about myself. (Participant 5)

I think it reached a point where I was making changes in my life like switching faculties, a different career . . . . I was making positive changes in my life . . . developing different interests . . . . So that the frequency [of bulimic episodes] definitely changed. (Participant 6)

Another woman who was focused on her reactions to pregnancy overcame bulimia.

I was so nauseated when I was pregnant. Only certain things would settle my stomach and I found that I didn't really care to eat so many foods. There were no thoughts of bingeing because food was disgusting to me. Once I started feeling good I started eating regular meals again. (Participant 7)

Another informal factor entailed the women coming to terms with their need to lose weight.

Coming to realize that I can't be super skinny. For me 125 pounds is my maintenance weight. So it's just being comfortable with what I am. (Participant 5)

I had to be very conscious of eating at least two meals a day, sometimes three. I couldn't handle it because I still thought I was going to get fat. But two meals a day, I knew

that if I ate lunch and supper and I didn't eat the junk food that I was going to be O.K. (Participant 4)

A further example of an informal factor that helped people overcome bulimia centered around relationships. Several of the women reported that when they left their husband or boyfriend, they began to get better.

> Not being brainwashed by someone else, like the boyfriend I had. It was when I got rid of him that I started getting better . . . . He was very destructive for me. (Participant 2)

> My husband had a lot to do . . . . with me even getting it. He wasn't very supportive when I was getting better . . . . and when I left my husband, that was when I did actually quit. (Participant 3)

Subsiding

It appeared that after the women took action, their bulimia subsided. As a function of taking action and experiencing a further opening of the self, the bulimia subsided. Subsiding was conceptualized as having three properties, gradual, forgetting about it and taking care of itself.

Gradual. As the opening of self progressed, the bulimic behavior subsided. It was a gradual process.

> I just found one day that I could go for an hour without eating and then went to an hour and a half . . . . All of a sudden I made it through half a day, which I was never able to do before in my life. (Participant 1)

So once everything started settling down a bit the behavior started slowing down to the point where the episodes were few and far between. (Participant 5)

The bulimia continued for awhile after going into Alanon, but it slowed down. (Participant 4)

I went on to be bulimic for three or four years [after therapy] but the severity was reduced. (Participant 6)

Forgetting about it. Some of the women reported that there were times when they forgot about food and their bulimia, which seemed very unusual. Forgetting about the bulimia was a second property of subsiding.

One day I woke up and thought I hadn't been thinking about food 24 hours a day that I'd forget to eat. I'd get busy at work and forget to eat. It was so subtle. Eating would have been the most important thing. (Participant 3)

I started having periods when I was doing other things and I would forget about even wanting to do it . . . . I started developing different interests in my life and I would forget to do it. (Participant 6)

Taking care of itself. Another property of the bulimia subsiding was that to some of the women the bulimia seemed to take care of itself, to work itself out.

Changes just kind of went on their own. I didn't have to do much. I became very healthy mentally and I didn't have to

concentrate so much on the bulimia. It just took care of itself. (Participant 4)

I think I just kind of went with it and realized it had alot to do with how I was feeling. If I worked on how I was feeling the bulimia would work itself out . . . . and I can't even remember when the last episode was. (Participant 5)

Recovered Stage

The third stage in the process of opening and recovery from bulimia was recovered. The women realized a point of being recovered. They said they chose to recover and that they knew the bulimia was over. Occasionally a relapse occurred for some of the women. Being recovered involved functioning better generally in their lives. The stage was comprised of five substantive codes with corresponding properties, stopping, choosing, knowing, relapsing and functioning better.

Stopping

Stopping was described as occurring in two ways. These properties were sudden and gradual. Further opening of the self seemed evident in that the women no longer needed bulimia to function in their lives.

Sudden. Some of the women reported a "sudden" point of stopping their bulimic behavior. The following statements indicate the women's experience of the bulimia stopping.

I was able to recognize what I was doing before I actually got into purging. When I was stuffing my face, I recognized, this is wrong and I stopped. Just cold turkey I

stopped. Every time I got the urge I would pick up the phone and talk to someone about how I was feeling. (Participant 4)

I decided it had to be [the cigarettes or the bulimia] and I thought which would I rather do . . . . Well I would rather smoke; bingeing I hated. So I said O.K. that's it. And really it was that easy . . . . I just decided to do it and I did it. (Participant 3)

Gradual. For some of the other women, a sudden point of stopping did not occur, instead the bulimia subsided gradually until it stopped.

Actually I never thought about it . . . . now they haven't happened for quite awhile . . . . once things started getting back on track . . . . the bulimia started to subside until it disappeared all together. (Participant 5)

I would go several days and think gee I haven't made myself sick and the periods just became longer and longer in between. (Participant 6)

Choosing Health

In respect to this characteristic of the bulimia stopping gradually, the women still reported that they "chose" to get better. In choosing healthy rather than bulimic behavior, it seemed that there was an opening of the self. Perhaps as a result of opening, the self developed a direction to reciprocally choose healthy behaviors and this entered into a positive feedback loop.

> I think I chose to get better . . . . I feel a lot more comfortable with it now that I do have a decision to make about it and that is that once the idea pops into my head, I don't have to do it. (Participant 5)

> I wanted to get better because I did, like anyone else who has a disease . . . . You just have to want to get better because you can't live like that. That's how it was for me. It just became impossible more all the time. (Participant 2)

In these cases, even though these women's bulimia stopped gradually, they were choosing to get better as time went on.

And even the woman who stopped because she was pregnant reported choosing to stop.

> I decided I wouldn't do it while I was pregnant . . . . The person who made the decision (to stop) was me and the person who actually, the day by day 24 hour, who knew what was happening was me . . . . It was a decision I made and I stuck with, a very conscious decision. No one else could stop me - I had to. (Participant 7)

Knowing

The women reported knowing certain things such as the bulimia being over yet never over. It seemed that as the self opened, the women became in touch with a knowing that was described as having two properties, over and never over.

Over. When the bulimia stopped, most of the participants reported knowing not to do it again and knowing that it had stopped and was over.

> [I've learned] never to do it again, that's easy. I would never do it again because it is a living hell. Now that I have got the victory, there is no way I would ever do it again. (Participant 1)

> At the time [I stopped] I knew that that was it, it was over . . . . I remember I was disappointed that [my psychiatrist] wasn't as enthused about it and I knew it was over. No problem at all. (Participant 3)

Never over. Also, the women said that they knew the bulimia was never over. This seemed to indicate that even though the critical aspects of the bulimia had ended, the potential for relapse was present.

> Sometimes I don't feel recovered because there is still room for improvement . . . . it is something you have to work at all the time . . . . I mean on yourself, making sure you are happy with you . . . . That was a six year pattern, real easy to start back into. (Participant 3)

> So I don't think I ever made the decision that it's not going to happen again because I don't know that . . . . Before it was like I didn't care and I'd give in to it. Now I think I care. (Participant 5)

Relapsing

Relapsing into bulimic behavior occurred for some of the women. For others, an awareness of potential relapsing was reported. Opening the self seemed to be indirectly related to relapsing. During times of relapse, it appeared the self was

closing rather than opening. It seems that an opening of the self occurred when the individual viewed this time as an opportunity for learning. Relapsing was conceptualized as having two properties, not always and learning.

In the stage recovered relapsing is addressed because the participants believed they had recovered. In addition, relapsing followed the notion discussed earlier that some of the women reported a knowing that bulimia is "never over", that a relapse is always a possibility.

> I knew it was over. I hadn't even thought about throwing up. Then at Christmas I got really down, my boyfriend and I split up for awhile, this divorce thing was getting to me and all of a sudden, twice in one week I threw up. I had no idea where it even came from, why I did it or anything. But then that was it. (Participant 3)

> It disappeared all together. Then when I first got married I had a few episodes. I think it was jealousy because my husband's first wife was really skinny and I felt second best. Then once we settled into the marriage . . . . a lot of that went away and I can't even remember when the last episode was. (Participant 5)

Finally, there were some women who did not relapse. Two women did not experience relapses after their bulimic behavior had stopped. One reported an awareness of the bulimia having a potential to return, and not wanting it to return. The woman who stopped because of pregnancy said

> It was over . . . . I didn't want to do that anymore. I wondered if that would come back and I always thought if it did, I would deal with it. (Participant 7)

Another woman had not experienced a relapse after her bulimic behavior stopped; however, she spoke about it in the following way.

> I joked about it once, after the baby, and the fear on my husband's face told me it was not something to joke about. It is a day to day thing, I am not going back there. Sometimes I have to take it a minute at a time . . . . The price is too high to pay to purge again. (Participant 4)

Variation. Relapsing could have been discussed in the action stage as some of the women felt a relapse was occurring during the time when their bulimia was subsiding, prematurely believing they were recovered. These "relapses" appeared to be an aspect of recovery pertaining to the cyclical nature of the recovery process from bulimia.

> In the period of recovery, yes I had a relapse. You think you've got it licked and then . . . . I learned that it is not so easy, that it's easy to go back. I got depressed and saw that I wasn't so tough. (Participant 2)

> I think I did [have a relapse] because I was getting so much better . . . . and I started relapsing when I was living with a man who was verbally abusive. I started being bulimic again. (Participant 5)

Learning. All of the women learned something from their relapses. For example,

> When I did throw up . . . . it scared me how easy it was to fall back into old patterns . . . . In a way, I think it was kind of good because it keeps you on your toes, you gotta keep working on it. (Participant 3)

Even those who did not relapse expressed knowledge of how a relapse could occur.

> If I'm happy, I don't even think about it. If it's stinkin' thinkin', I do something about it. I call someone [because] that's when my bulimic tendencies start to come back. (Participant 4)

Another woman expressed learning from the relapses she experienced while still in the action stage.

> From relapsing, I would get a little discouraged but I also learned towards the end that well if I relapsed I would try not to let it ruin my day and that I still had a chance to try again and avoid it. (Participant 6)

Functioning Better

As a result of the process of opening the self and recovering from bulimia nervosa, the women fuctioned better in their lives. Functioning better was conceptualized as having two properties, inner-directed and generally-happier.

Inner-directed. Being inner-directed described the particiapnts process of functioning better in their lives since the bulimia had stopped. All of the women expressed being more in

control of their lives and not so concerned about what others said.

> But I'm very happy with what I've become compared to what I was. I'm more my own person now. I don't have to please anybody anymore. I was a real people pleaser before. Now I do what is good for me. Before I would be what everybody else wanted me to be. Now I'm just me and people either accept me or they don't. (Participant 4)

> How I feel about myself is better, when someone talked to me I didn't talk back. I was shy. Now I feel a lot more open with everything. I'm more my own person now. I was too concerned about what everyone else thought and not what I thought. (Participant 5)

Generally-happier. Generally speaking, since the women's bulimic behavior had stopped, they reported being happy, to be more themselves and to like themselves.

> Now I like myself . . . . I am more my own person now . . . . I feel like I am me . . . . [now] I am easier to be around . . . . I am likeable . . . . I smile, I am friendly, I just like myself. (Participant 3)

> I like myself, I like what I see . . . . Now I recognize all the positive. I feel good about me now. I'm happy with who I am . . . . I know who I am . . . . It is O.K. to have faults . . . . I am much more positive . . . . I'm honest. I'm so happy now. (Participant 4)

Maintenance Stage

Maintenance involved the women continuing their healthy behaviors. They reported three ways which were involved in maintaining health: eating, exercise and negative feelings and thoughts. The maintenance stage was conceptualized as having three substantive codes: eating, exercising and monitoring feelings.

Eating

When asked if they had any kind of maintenance program, the women stated that they allow themselves to eat whatever they wish, but in moderation. This regulation of eating appeared in all of the interviews with minor variations. Opening the self seemed to be present in an openness to messages from the body and the self regarding what to eat.

> I enjoy eating everything; I don't exc' e anything from my diet anymore. (Participant 7)

> I still eat the rich foods I love, like whipping cream in my fettucini, you know, but in moderation. (Participant 1)

> I don't watch what I eat, but I watch how much I eat at one time . . . . I want to feel satisfied but not full. (Participant 3)

Another woman added that she didn't really have a maintenance program but she did watch how much she ate. In a sense, this was a form of regulatory behavior in order to carry on recovery from bulimia nervosa.

> Not really anything except to recognize if I'm eating too much . . . . Now I rarely eat between meals. I eat three meals a day . . . . Just being conscious of what I eat. (Participant 5)

The last example of variation in this code was a woman who ate healthily and tried to stay away from sweets. Also, she mentioned "exercise", the next substantive code of this stage.

> I have to really concentrate on eating healthy. My husband is diabetic, so we follow the Canada Food Guide for Diabetics. I try to stay away from the sweets. Licorice and cookies are a weakness, but that's O.K. as long as I don't eat the whole bag, that's O.K. It is alright to treat myself. Exercising is good too. (Participant 4)

Exercising

Exercise was mentioned by most of the participants as a means of maintaining recovery in addition to eating well. It appeared that by nurturing the body by exercising, opening of the self was facilitated which helped maintain the recovered state from bulimia.

> Being in the field that I am in [dietician], I eat a well balanced diet and have a regular exercise program. (Participant 6)

> I walk for an hour every morning before work and pray . . . . when I started to walk, I lost 12 pounds without even trying. (Participant 1)

> I do still exercise, but I'm not a fanatic and I don't care if I miss a day. (Participant 3)

Monitoring Feelings

The last code of this stage was monitoring feelings. It seemed that openness of the self was related to learning that bulimia was connected to feelings and thoughts. Opening the self seemed related to changing negative behaviors to ones more positive. One of the women reported knowledge of a connection between her feelings and her behavior and acted accordingly. She reported this as the main aspect of maintenance.

> I mentally follow my Alanon program. I go every week. I keep in touch with my own feelings. Like when I feel low, I recognize why because that's when I slip . . . So it's mainly maintenance of my own feelings. (Participant 4)

Another woman reported focusing on other aspects of herself as part of maintenance. She gave this more importance than the aspect of eating.

> [I] used to try clothes that were too tight and too small and I don't do that anymore . . . . My most conscious effort is to look at my positive points and to quit trying to make everything so perfect and I don't do it with other people. (Participant 7)

Summary

The supporting statements from the seven participant interviews illustrate the proposed process of recovery from bulimia nervosa. The stages of the recovery from bulimia were contemplation, action, recovered and maintenance. "Opening the

self" emerged as the basic psychosocial process of recovery from bulimia. The 4 stage theory of recovery described changes over time, which occured in "opening the self". The stages and substantive codes and properties were integrated into the whole process of recovery. Recovery from bulimia was conceptualized as progressing through stages. The transition from stage to stage was sometimes clearly marked by an indicator. For example, the beginning of the contemplation stage was clearly marked by realizing the behavior. In the case of the transition from the contemplation stage to the action stage, the indicator was taking some kind of action such as telling someone about the bulimia, seeking formal treatment or informal factors.

The transition from the action stage to the recovered stage was not as clearly marked in some cases. For instance, some of the women reported prematurely that they were recovered. Actually, they seemed to be in the action stage with the bulimia subsiding. This pertains to the cyclical nature of recovery. The transition was clearly marked by some of the women's conviction that they were recovered. For others, recovery was clearly marked by the lengthy time since the last episode of bulimic behavior.

The transition from the recovered stage to the maintenance stage was clearly marked. The women reported being recovered and behaving in ways which maintained their health in relation to eating, exercising and their feelings and thoughts.

The stages of contemplation and action were clearly demarcated. However, it appeared that aspects of contemplation and action occurred in the recovered and maintenance stages. For instance, even though the women were recovered, there were times when negative thoughts occurred which were deemed as a precursor

to bulimia. It seemed that contemplation followed by action occurred in response to these negative aspects.

Stages seemed to be a useful method of integrating the experiences of recovery from bulimia nervosa. The stages seemed to differentiate and account for variations in the patterns of behavior.

CHAPTER VI - EVALUATING TRUSTWORTHINESS

This chapter presents the criteria for evaluating the theory of recovery from bulimia as proposed by Glaser and Strauss (1967). Also discussed will be the criteria used in determining the trustworthiness of the theory of recovery from bulimia (Guba, 1981). Finally, the usefulness of the theory of recovery for people working in the substantive area will be addressed.

Evaluating the Theory

The theory of recovery was evaluated and found to be believable, adequate, grounded and applicable.

Believable. A person working in the field of mental health with sexual abuse victims for four years was chosen as a reader to establish believability. To her the theory seemed well explicated and believable. She believed that the theory of recovery from bulimia could be applied to counselling victims of sexual abuse. Also, "opening the self" may be a revelant conceptualization for recovery from sexual abuse. These comments helped confirm the believability of the theory.

Adequate. The auditor wrote in his report that the analysis of data did not omit important segments of the data. The auditor suggested highlighting the resolution of an unsatisfactory relationship with a husband or boyfriend as pertinent to recovery for some participants (see Appendix G). This was done in relation to informal factors and added to Chapter V.

Grounded. The process of "opening the self" emerged out of the narratives of the participants, as a main theme in their experiences. When the description of the process was presented to six participants, they each stated that the theory reflected their

own experience. Participant 6 for example, said that the theory followed everything in the recovery process. Confirmation from participants supported the theory being grounded.

Applicable. Later investigations could involve determining how the theory of recovery for bulimia applies for recovered bulimics with a history of anorexia, obesity, or drug and alcohol abuse. Further research could involve persons recovered for longer periods of time than the women in the current study.

Trustworthiness

Meetings with the dissertation committee and the peer group, thick description, member checks and auditor's report are discussed. These methods are used to test credibility, transferability, dependability and confirmability of the theory of recovery from bulimia. Consensual validation is addressed last.

Dissertation Committee and Peer Group

During the research process, meetings with the dissertation committee and the peer group were used to establish credibility. These meetings were conducted weekly and sometimes bi-weekly. The meetings were useful in discussing research questions such as negative case examples and sampling issues.

Thick Description

Thick description was collected for the criteria of transferability. These descriptive data were collected using the questionnaire of demographic data and the interview questions. The description of the participants contains summaries of the thick description.
(see Appendix D).

Member Checks

For establishing credibility of the theory, member checks were used during and after the research. During the research participants were reinterviewed in order to expand on some concepts. For example, one participant reported that telling someone about the bulimia was very important for her recovery. Thus checks were made with the other participants to establish the importance of telling for them.

After the research was completed, six of the seven participants read Chapter V, Description of the Process of Opening the Self. Participant 1 had moved and was unlisted in the telephone directory. She could not be reached and, therefore, never read chapter V. The other women obtained chapter V before the final draft was approved by the thesis committee. The participants were asked to provide feedback which could consist of adding to, deleting or changing the theory. They were told that the theory may not require revisions.

All six persons responded, after reading the theory. Participant 4 was the most excited about the theory. She said she was very impressed with the job the researcher had done. It was wonderful. She expected it to be more clinical. The theory of recovery was instead, "down to earth and readable". She felt everybody would be able to understand the theory. She felt that everybody's responses had come from "the gut". The participant gave the theory to her mother to read. She reported that her mother was surprised at how difficult the experience had been for her daughter. The mother seemed to realize that the theory was a credible account of her daughter's recovery from bulimia.

Participant 2 reported that the theory seemed fine. She felt it was interesting and that a lot of similarities to herself were in the theory. She gave it to her husband to read. He said he understood the disorder better. He was impressed with the theory.

Participant 5 said it was "very good". She had no problem with it. She went over it and felt good about it afterwards. She said nothing had been left out.

Participant 3 said she really thought it "was good". She really liked the stages of the theory and felt they could relate to the recovery processes of any addiction. She found it interesting how all of the participants were different in their recovery process regarding treatment and stopping. Also, how each person described her experiences related to bulimia was valuable to her. She was impressed by the inclusion of the codes choosing and inner-directedness as important aspects of the recovery process.

Participant 6 said the theory sounded reasonable. The theory was similar to her experience of bulimia. Ideas that she had not discussed during the interview applied to her. For example, she used different strategies such as getting out of the house and phoning a friend when the urge to binge occurred. The theory made a lot of sense for her. She could see the progression and it seemed to fit for her. The participant felt it was interesting to read other people's experience and think " I could have tried that too!" From the similarities of the experiences, the participant felt a sense of security. She also felt secure that other people maintained recovery; therefore, so could she.

Finally, participant 7 said that she could see herself in other people's comments. She noticed that other people dealt with their bulimia differently such as professional help, Alanon and religion. She felt that the theory "brought things together". The participant said that the material she read included important comments, such as feeling free and less trapped. She thought the feelings of the participants were very similar and only the strategies of recovery were different. For her the theory was straight forward and easily understood. Participant 7 suggested adding that if one binges, the next step is purging and then the bulimia could come back. She said it is easy to do. She felt this notion was expressed in the maintenance stage and needed to be expounded upon more.

Credibility of the theory was established from the feedback of the participants in that they reported the findings to be true to their experience. Another type of member check was used to further establish credibility, the non-participant reader.

Non-participant readers. The theory was read by two persons with characteristics similar to the participants in the study. They had not been interviewed for the study. These recovered bulimics read the theory and provided feedback.

The first person was a man, aged 34. He was bulimic for 5 years and does not recall how it began. He has been recovered for 9 years. He only experienced informal treatment. He said that there was nothing to change in the theory. He thought it was interesting to read. He had looked through books on bulimia before, but never saw any he wanted to read. He always wanted to talk to someone about bulimia. This was the first time he had talked to anyone at length. He felt the stage aspect of the

theory was very accurate. He thought the participants were a suitable population for a representative sample of bulimics. The only difference the man found in comparing his own experience to the theory was the issue of relapsing. For him, he did not believe that the bulimia could return.

The second person who read the theory was a woman aged 20. She had bulimia for 2 years. She has been recovered for over a year. She did not receive formal treatment. She stopped suddenly because she realized the negative health consequences of the behavior. The woman said the theory made sense to her. This person wrote a paper on bulimia for a course she was taking at college. She saw similar patterns in herself. She had realized that her eating was covering up other problems. She thought, before reading the theory, that the bulimia could never come back. After reading the theory, the woman said she was aware that it could come back, that she is vulnerable. She said this was positive in making her aware that if the bulimia did start to come back, she would know it was because something else was occurring in her life. This woman suggested that the theory should discuss more explicitly the role of self-esteem in bulimics. However, the term self-esteem did not appear in the data analysis; therefore, only terms that emerged in the study were used in order to be true to the data.

From the responses given by the participants and non-participants, it seems that these checks establish credibility of the theory.

Auditor. In order to establish dependability of the theory, an auditor examined in depth the researcher's audit trail. In establishing confirmability of the theory, the auditor determined

that data existed in support of interpretations generated by the researcher.

Dependability. The auditor reported that the researcher's audit trail showed evidence of care taken to achieve saturation on variables. The audit trail exhibited the back and forth interplay which occurs in the development of substantive theory from data. The audit trail demonstrated that the procedures used appeared to be well within the normal bounds established for this type of theorizing. (see Appendix G).

Confirmability. The auditor wrote that the stages of the recovery process from bulimia were well supported by direct quotations from subject interviews. Hypotheses were not generated beyond information contained in the quotations. The auditor stated that quotations were used to demonstrate differences and similarities in the process of recovery. The differences which did arise were indicated and shown to be consistent with the hypothesized process of recovery. Finally, the auditor felt confident that the hypotheses and interpretations were supported by and consistent with the collected data. (see Appendix G).

Consensual Validation

In determining if participants agreed about their understanding of the purpose of the study and the interviewer being present in a human way, they were asked the following questions. "What do you feel was the purpose of the study?" "How did you experience me?"

Purposes of the Study

Four themes pertaining to the purpose of the study emerged from an examination of participants' responses to these questions.

They were: to understand the experience of recovery, to help others suffering from bulimia, that bulimia is not very well known and to find out the participant's experience of bulimia.

The first theme was to understand the experience of recovery. Three participants believed the purpose of the study was "to understand what leads bulimics to recover and what motivates them to recover" (Participant 6), "To find out . . . the facts, how people are dealing with it. You're trying to find out more about it" (Participant 2). A variation on the theme of understanding the experience of recovery is "to get a better understanding of the disease or the addiction . . . . . so that we can find ways to solve it" (Participant 7).

The second theme was to help others. Three participants responded that the purpose of the study was to "help other people understand what recovery is all about with bulimics . . . . . and that other people will be able to recognize their own tendencies by seeing that there is hope that they can recover from it. If we can recover, so can they" (Participant 4); "you are wanting to help others recover from these situations . . . . There is a great need out there for people" (Participant 1). Finally, "to make other people aware of the causes behind bulimia and see different roads to recovery that you can take."
(Participant 5).

The third theme was that bulimia is not well known. Two participants addressed this notion. They stated that "bulimia was such a new field, an area that has not had a lot of research done. " (Participant 7) and "it is a big problem and I don't think enough people [knew about it] . . . . it wasn't talked about much" (Participant 2).

The fourth theme addressed was to find out the person's experience of bulimia. One participant stated that the purpose of the study was "to find out my story about my experience of bulimia" (Participant 3).

The stated purpose of the study was "to discover a common theme of the experience of recovering from bulimia nervosa by interviewing recovered bulimics and recording their views." The majority of responses indicated an understanding of this purpose.

Self Presentation

The following question was asked "How did you experience me?" This question was used to ascertain the consistency of the manner in which the interviewer was present in the interview. The participants stated that the interviewer was:

> "Pleasant. You seem like a very nice person." (Participant 1)
>
> "Oh, great. It seems like you had a little bit of background like mine and that is comforting." (Participant 2)
>
> "You were easy to talk to; it was no problem at all. You understand the answers which is important because you've been there and some people might think I'm a freak. It was easy, really easy." (Participant 3)
>
> "I thought you were great, really warm and understanding. It was very casual. It was fun." (Participant 4)

"I found you to be general with the questions, not leading and you made me feel comfortable because at first with the tape, I felt kind of uncomfortable and then once we started talking, I felt better. I think it went really well." (Participant 5)

"Encouraging, you certainly sound like a friendly person." (Participant 6)

"Well, because we are in my home, I feel good here and I feel comfortable talking to you. I don't have a problem with that at all." (Participant 7)

These responses indicated that the participants perceived themselves as comfortable with the interviewer. The interviewer was found to be sensitive, warm and understanding, thus acting in a human way.

Usefulness of the Theory

A theory must be useful and meaningful for people working in the substantive area. Chapters IV Theory Overview and V Description of the Process, were given to two people working with bulimics.

A woman working with bulimics for four years thought the theory of recovery for bulimia made a lot of sense. She understood the theory and it was not too difficult to read. The woman had not put words to the process of recovery but saw that it happens as the theory described. She could see how her clients fit the stages of the theory. Maintenance was a new word she found helpful. Also, she considered opening of the self to be

critical in the change process. She said she will look for the stages in her clients during counselling.

The second person was a psychiatrist. He felt the stages were common sense. The theory covered everything in the process of recovery except for the issue of weight. In his work, weight gain is always a critical factor. He especially liked the first step of realizing the behavior and then telling someone about the behavior. The psychiatrist said he would remember the theory in his work with bulimics.

The theory appears to be useful and meaningful for both of these persons. It is usable in that both said they would be aware of the theory of recovery for bulimia during their work, thereby identifying where clients might be in the theory. In response to the psychiatrist's criticism of the theory lacking emphasis about bulimics' concern with weight, a section was added under informal treatment factors addressing this issue for recovery. The women reported the issue of weight as one of many factors, in their process of recovery from bulimia nervosa. Weight did not appear to be the most significant factor but was mentioned by all the women and thereby considered as important enough to include.

Summary

The theory of recovery from bulimia nervosa was demonstrated as being a grounded theory as it was found to be believable, adequate, grounded and applicable. Also, it was trustworthy according to tests of credibility, transferability, dependability and confirmability. Consensual validation demonstrated that participants understood and answered to the purpose of the study. The interviewer was considered as acting in a human way by the participants. Finally, it was found that the theory of recovery for bulimia was useful according to two persons working in the field of bulimia.

CHAPTER VII

DISCUSSION OF THE THEORY

> Within [her] something was opening, releasing shyly as the petals of a flower open, with such gradualness that [she] was hardly aware of it. But it was happening: an alchemy imperceptible as the morning wind, a growing elation of such fleeting delicacy . . .
>
> W. O. Mitchell

Introduction

Opening the self, the basic psychosocial process (BPSP), is the main theme of recovery from bulimia nervosa. It reoccurs throughout the theory of recovery. It is central to the data in that it relates to all of the codes and properties. Opening the self appears in varying degrees throughout the theory of recovery.

This chapter begins with an examination of the secondary literature review pertaining to general findings and implications of qualitative and quantitative methodologies. Next, the self becoming closed and developing bulimia is examined. Then, becoming open is addressed in relation to the stages of contemplation and action followed by the characteristics developed as a result of opening, in relation to the stages recovered and maintenance. Finally, five themes pertinent to the discussion of the theory of recovery are discussed: feedback loop, epigenesis, continued change, reframing and treating the whole person.

Secondary Literature Review

It is interesting to note that the literature on bulimia nervosa says very little about the process of recovery. It was necessary to search literature on other models of recovery

pertaining to health related addictions to provide comparisons for codes that emerged from the data (see Table 3). The areas were delinquency, alcohol and drug abuse, smoking, obesity and anorexia nervosa. All of the studies used a quantitative methodology except for one (Stuck and Glassner, 1985) which used a qualitative approach. These articles on "recovery" from delinquency, alcohol and drug abuse, smoking, obesity and anorexia nervosa, primarily focused on what the individuals did to recover, but did not discuss the experience of recovery. In most of this literature, recovery is in some sense synonymous with processes of change. For example a 20 year-old white male delinquent achieved non-involvement in drug use and criminal activity. The authors referred to his non-involvement as a process of change (Stuck & Glassner, 1985). Daley (1989) referred to abstinence from alcohol and substance abuse as a recovery process. Smoking cessation was described as a process of change by Prochaska and DiClemente (1982). Recovery from bulimia and anorexia was described as a process of change (Buchmann & Röhr, 1983). Therefore, the literature on these health related areas was examined relative to recovery. (For an indepth review of the secondary literature see Appendix H). Generally speaking, comparisons could be made from results of the quantitative studies in the secondary literature review.

The comparisons were helpful in demonstrating which aspects of the experience of recovery were addressed directly, indirectly and not at all. Concepts which were addressed directly by the literature review pertained to aspects of recovery accessible by both qualitative and quantitative methods. Examples are: stages people experience in recovery; aspects of motivation influencing

Table 3

Secondary Literature Review Compared to Codes.

THEORETICAL AND SUBSTANTIVE CODES AND PROPERTIES	SECONDARY LITERATURE REVIEW
Opening	Rogers, 1987
Self	Whelen & Prince, 1982; Lewis, 1987; Clarkson, 1989; Perri, 1985; Perls, 1969 and Stuck & Glassner, 1985.
Personal Resolve	Jackson, 1986; Brownell, Marlatt, Lichenstein & Wilson, 1986; Brammer, 1984; Maslow, 1962 and Perri, 1985.
Stages	Daley, 1989; Horn, 1976; Brownell et al., 1986 and Prochaska & Diclemente, 1986.
Temporal Factor	DiClemente & Prochaska, 1985.
Cyclical Pattern	DiClemente & Prochaska, 1982 and DiClemente & Prochaska, 1985.
1) Contemplation Stage i) Realizing Behavior	
1 - media	Clarkson, 1989 and Doerr & Hutchins, 1981.
2 - getting caught	Stuck & Glassner, 1985 and Prochaska & DiClemente, 1986.

3 - intrinsic	Lewis, 1987 and Clarkson, 1989.
ii) Generating Motivation 1 - internal 2 - external	Wilcox, Prochaska, Velicer & DiClemente, 1985; Perri, 1985 and Daley, 1989.
2) Action Stage i) Taking Action 1 - telling	France, McDowell & Knowles, 1984.
2 - formal treatment	Wilms, 1986; Backman & Röhr, 1984; Lawrie, 1982 and Sherin, 1983.
3 - informal factors	Watzlawick, Weakland & Fisch, 1982; Perri, 1985; Prochaska & DiClemente, 1985 and Westermeyer, 1989.
ii) Subsiding 1 - gradual	not addressed
2 - forgetting about it	not addressed
3 - taking care of itself	not addressed
3) Recovered Stage i) Stopping 1 - sudden	Edwards, Simmons, Rosenthal, Hoon et al., 1988 and Gunn, 1986.
2 - gradual	not addressed

ii) Choosing Health	not addressed
iii) Knowing	Brownell et al., 1986; Bandura, 1977; Maddux & Rogers, 1983; Prochaska & DiClemente, 1985; DiClemente, 1981 and Prochaska & DiClemente, 1986.
iv) Relapsing 1 - not always 2 - learning	Wilcox et al., 1985; Prochaska & DiClemente, 1986; Brownell et al., 1986 and Daley, 1989.
v) Functioning Better 1 - inner-directed 2 - generally happier	Inbody & Ellis, 1985.
4) Maintenance Stage	DiClemente & Prochaska, 1982; Daley, 1989 and Brownell et al., 1986.
i) Eating	not addressed
ii) Exercising	Brownell et al., 1986.
iii) Monitoring Feelings	Daley (1989) and Brownell et al., (1986).

resolve to change, such as motives; strategies and treatment methods people engage in to become well and patterns of recovery related to cycles of ebbs and flows which occur over time.

Concepts which were addressed indirectly by the literature review pertained to similar characteristics of recovery which were conceptualized differently from terminology which emerged from the current study. Examples are: aspects of opening the self such as being open to oneself and others; ways people realize that their behavior is unhealthy such as media or getting caught; how opening up to others is helpful in alleviating loneliness; how an individual's belief about being able to cope influences behavior and aspects of maintaining health involving the self and the body.

The concepts which were not addressed by the literature review pertained to characteristics of recovery of a qualitative nature, for instance: the importance of telling as a first or subsequent step; how the bulimia subsides and stops gradually; how individuals become less focused on their dis-ease; how the bulimia is characterized as taking care of itself and finally how eating attitudes change.

These comparisons illustrate the differences which may occur when individuals are interviewed and when individuals are given questionnaires. Interviewing frequently lends itself to the collection of qualitative data. Questionnaires are often used for purposes of quantification. Significant differences exist between the two methods. For instance, interviews usually occur in a social context where the interviewer acts in a supportive manner. This personal intervention stimulates people to respond. New ideas may develop from this interaction between the individuals.

A wider breadth of experience is addressed. On the other hand, questionnaires are usually given in an impersonal setting. The written form is constrained. These differences in the methods may explain the differences in data collected. The qualitative approach encourages greater opening and sharing and thus greater depth and detail to the data collected.

The literature review was helpful in demonstrating the gap in the bulimia research on the process of recovery. Research focuses on what works and for whom but does not examine the experience of recovery from the perspective of the individual.

Finally it is apparent that the main theme of recovery "opening the self" is an aspect of change not addressed directly in research literature. It seems pertinent that the self must open in order to change. The absence of this notion may be partly explained by quantitative research methodology which is to have a hypothesis in mind before the commencement of research. The hypothesis is then tested and quantified. Thus, it seems that the significance of the self opening in order to change has not been hypothesized.

Opening the Self

The literature was searched for information pertaining to the BPSP opening the self. It seems that very little empirical research focuses specifically on opening the self. However, humanistic theorists such as Rogers (1982), Maslow (1962), Perls (1969) and others have repeatedly emphasized the importance of openness for psychological health and growth. For instance, Rogers (1982) wrote that as a result of client-centered therapy,

people became open to themselves and others. Maslow (1962) stated that healthy growth involves the characteristic of openness, similar to that of a young child. Perls (1969) wrote that an openness to the experience of the self results from awareness of introjection, projection and retroflection (Van De Riet, Korb & Gorrell, 1980). Borysenko (1987) stated that healthy development involves being open to an awareness of the moment. France, McDowell and Knowles (1984) wrote that individuals who opened up to others were helped in coping with feelings of loneliness.

Many related aspects of opening the self are addressed in the research literature. For instance, change and growth seem to occur as a result of opening. Research addresses processes of change (Stuck & Glassner, 1985 and Borysenko, 1987) and processes of growth (Daley, 1989 and Lowe, 1989). Also being inner-directed seems to occur as a result of opening. The notion of inner-directedness is significant in discussions of change and growth (Rogers, 1987; Maslow, 1966; Perls, 1969; Lowe, 1989; Stuck & Glassner, 1985 and Borysenko, 1987). Being open and recovered results in other characteristics such as honesty, healthy choosing, knowing, and organismic-regulation.

These characteristics of openness will be discussed in relation to dimensions of being closed and developing bulimia and openness during the recovery from bulimia. In order to avoid repetition, indicators from the participant interviews are only used to illustrate certain concepts not addressed in Chapter V, such as control and honesty.

Becoming Closed and Bulimic

In this study opening the self emerged as a main theme of recovery from bulimia. Change in the self is implied by this concept, where opening moves the person towards health and closing sets the stage for the generation of unhealthy behaviors.

In the process of the development of the self the experiences of the individual can lead to a healthy or unhealthy psychological positioning. In describing healthy people Rogers (1987) wrote that some of the key factors in healthy people are an openness to the self, trusting the self, openness to experience, openness to change and being inner-directed. On the other hand, unhealthy behavior or dis-ease is characterized by being out of touch with the self, resistance to change, lack of personal control, and denial of personal experience (Van De Riet et al., 1980).

Maslow wrote that our inner nature is easily "drowned out by learning", by cultural expectations, by fear, by disapproval," by our conditioning generally (1962, p. 261). The suppression of the self usually begins when socializing agents try to direct children, to teach them things. They criticize them, correct their errors, and attempt to give them the right answers. Consequently, children stop trusting themselves and their senses and depend on the opinion of others (Maslow, 1962).

The closing of the self is a very gradual process. Each time an incident occurs the self closes. The infant is no longer in contact with its own inner wisdom. Through the defence mechanisms of introjection, retroflection and projection individuals lose touch with the emerging self and begin to act

according to the demands of the environment (Perls, Hefferline & Goodman, 1955; Van De Riet et al., 1980 and Clarkson, 1989). As a result of extrinsic socialization the authentic self fails to grow and closure to real inner needs is arrested (Maslow, 1962). These experiences of socialization result in disturbances in organismic-self-regulation (Clarkson, 1989). Persons with bulimia may be seen as having severe deficits in self-regulation (Goodsitt, 1983). As eating habits became more disordered, organismic-self-regulation, the internal signal to eat, becomes obsolete (Orbach, 1984).

The inner nature is not strong like the instincts in animals. The inner voice is subtle, delicate, and soft. It is covered up by external conditioning. Even though the inner core can be drowned out by learning, it never disappears altogether. It persists underground, in the unconscious and speaks to us quietly, as an inner voice waiting to be heard. Our inner core is a pressure called the "will to health" and it is this urge on which all successful psychotherapy is based (Maslow, 1962, p. 261). The principle strategy of Gestalt work is to develop inner personal strengths and supports, rather than relying on others (Brammer, 1984). The assumption is that growth is more likely to emerge after this inner shift takes place.

Becoming Open

Creating positive change for people appears to be dependent upon people opening to the growth of the self which may be an important factor in all forms of recovery from dis-ease. Rogers (1987) wrote that through client-centered therapy, the person

becomes more open to personal experience. The client becomes more open to all stimuli within, more aware of feelings and other persons' feelings.

In the process of recovery from bulimia, opening begins as the individuals realize that they have bulimia. An opening of one's self to symptoms and consequences occurs where change is contemplated. This leads to an opening of the self to take action. As the self opens further, the bulimia subsides accordingly. Eventually a state of recovery occurs and then the healthy behavior is maintained.

This description is a simplified account of how the self becomes open and recovers from bulimia. An in-depth examination demonstrates the process of opening and recovery as involving many factors with an idiosyncratic temporal factor and cyclical pattern. It seems that at a particular time, an interaction and combination occurs between elements such as the self, personal resolve, motives, formal treatment and informal factors. Recovery proceeds in a cyclical manner. "It's never one thing" (Participant 3) and "I guess a combination of all of [the factors]" (Participant 7). Stuck and Glassner (1985) wrote that a readiness to change occurs because of an experiential factor which interacts with both subjective and structural elements to cause a change.

Contemplation Stage

Opening the self involves a combination and interaction of factors at each stage of the recovery process. The process of opening and recovery begins by the individuals realizing that they

have bulimia and that it is unhealthy. "Realizing the behavior" describes the process of opening one's self to acknowledging symptoms and consequences. Realizing is achieved because of exposure to media, by getting caught doing the behavior or by an intrinsic knowing.

In the literature, realizing is most closely described by the term awareness. Lewis (1987) wrote that self-awareness is a basic mechanism of change. The power to change through awareness is supported by numerous theorists (Borysenko, 1987; Lowe, 1989; Orbach, 1984 and Perls, 1969). By acknowledging the seriousness of a problem an individual becomes motivated to seek help (Daley, 1989). Clarkson (1989) wrote that an individual may become aware of the self through magazine articles or radio programs. Also, individuals commonly become aware of the desire to seek help when there is some disturbance to the homeostasis of their lives. The awareness of the state of the self acts as a trigger to seek help.

A further opening in contemplating change involves an examination of reasons for changing the bulimic behavior which helps the individuals decide to take some kind of action. These reasons for changing are conceptualized as internal and external motives which generate motivation to change.

The research addresses motives but not in relation to opening the self. Motives such as desire for health will help individuals develop new behaviors (Perri, 1985). Fear for one's life, threat of divorce and the possibility of being fired from one's job are motivators for treatment so common that they are seldom studied as factors in outcome for substance abuse such as tobacco, alcohol and opiates (Westermeyer, 1989). Daley (1989)

wrote that initially external motives such as wanting to save a marriage, or wanting to nurture children, may be sufficient in motivating persons to change. It seems that there is an internal quality to the motive in that the person is choosing to consider stopping the addictive behavior. Perhaps eventually the motive to change becomes more internal. For alcohol and substance abuse, eventually the motivation must become internalized in order to maintain change (Daley, 1989).

The findings apply to this study since the women reported similar motives as generating motivation to change. However, the research articles did not address the notion that external motives have an internal reference point. Both internal and external factors are involved in relation to external motives.

Action Stage

In the action stage opening the self relates in three ways; opening to others in the telling about the behavior, opening the self to formal treatment and opening the self to informal factors. The self opens more as a result of these actions.

For most of the women, the first step of taking action was telling someone about the behavior. France, McDowell and Knowles (1984) wrote that opening to others helps individuals cope with loneliness. They felt less lonely after opening to others. Loneliness is accompanied by the feelings that there is nothing useful to offer others. In this study, opening to others is reported as helping the women cope with their bulimia. Opening to others helped the women take further action.

Opening one's self to treatment is the second way opening is related to the action stage. Authors discussing therapy do not refer to opening the self directly. They discuss aspects of therapy which help the self to open. For instance, Orbach's (1984) treatment approaches deal with bringing awareness to patterns of behavior and to issues around eating such as hiding binges. Wolchik et al., (1986) use treatment strategies to teach persons to learn new ways of coping besides bingeing and purging. Pope and Hudson (1984) wrote that most treatment approaches are effective in promoting change for bulimics. It seems that bringing awareness to the self and teaching strategies for more effective coping are ways of helping persons become open.

Opening one's self to informal factors is the third way opening is related to the action stage. Women in the study reported informal factors used to purposefully deal with the bulimia, such as going to Alanon, calling a friend, getting active and praying. Also, women reported engaging in informal factors which were not sought to purposefully deal with the bulimia. Examples are: moving to a new apartment; getting a job; going out with friends, being pregnant and developing new interests. These informal factors are seen as aspects of opening the self and as alleviating the bulimia. Westermeyer (1989) reported work, friends, church and relocating as nontreatment factors significant for recovery from alcohol abuse. Perri (1985) wrote that people who recovered from smoking, obesity and problem drinking had more support from friends and others, such as people from Alcoholics Anonymous, than those who did not recover. These findings may be applied to this study since some women reported similar informal

factors relevant to their recovery. It is noteworthy that the notion of the intention to recover is not addressed in the articles.

Das (1989) wrote that in the process of change, experiences seen as enhancing the self concept such as getting a job, seem to be positively valued and those considered as detrimental such as bulimia, seem to be negatively valued. In healthy development, the self and the organism are in a state of harmony in valuing what is positive and what is negative (Das, 1989). These findings may apply to this study in that women reported engaging in informal factors without intending to alleviate their bulimia. Perhaps the inner wisdom of the self valued the informal factors as beneficial.

It is noteworthy that participants in this study recovered using informal factors only. Changing without formal treatment has been addressed by many authors. For instance, Perri (1985) wrote that many people are capable of changing behaviors such as smoking, obesity and problem drinking on their own (Perri, 1985). In a study by DiClemente and Prochaska (1982) self-quitters were able to maintain cessation of smoking as well as individuals who attended treatment programs. In the process of change, people are capable of self-correction (Watzlawick, Weakland and Fisch, 1982). DiClemente and Prochaska (1985) wrote that individuals who present themselves for treatment can be viewed as self-change failures because they were unable to change on their own. Furthermore, self-change should be the backdrop for any therapy-assisted change.

As the women open themselves to others, treatment and informal factors, their bulimia subsides. Subsiding is described as having three properties: gradual; forgetting about it and the bulimia taking care of itself. It seems that an opening of the self enables a gradual reduction of bulimic symptoms whereby the individual forgets about the bulimia and it begins to take care of itself.

Research was not found pertaining to subsiding, the three properties or the relationship to opening. However, research pertaining to treatment outcome may be referring to subsiding in an indirect way. For example, Lacey (1984) found in a controlled study that 24 of the 30 persons studied had stopped the bulimia completely. The other six persons were described as having a reduction of symptoms. The reduction of symptoms may be indicative of the bulimia subsiding.

Recovered Stage

At this point of the recovery process, the self has opened enough to have achieved a recovered state. As a result of opening and recovery, characteristics emerge such as choosing, knowing, control and inner-directedness and finally honesty.

In this study, all of the women reported choosing to stop bulimic behavior. In choosing healthy behaviors instead of bulimic behaviors, it seems the self has opened to a way of being that feels intrinsically correct. As a result of this opening, the person chooses health over bulimic behavior.

Considerable literature exists to support that it is a natural state of the organism to choose healthy ways of being

rather than unhealthy ways. Perls (1969) suggests that because of organismic-self-regulation, healthy ways of being are naturally chosen. The inner wisdom of the self knows exactly what is healthful and what is damaging (Lowe, 1989). Life tends towards wholeness and growth in healthy development (Borysenko, 1987). Each person is free to choose responses and actions in any circumstance, and when the self-regulation is used as a guide, choices may become positive (Van De Riet et al., 1980).

The women in this study reported knowing the bulimia was primarily over. Also, they reported knowing it had the potential to return under certain conditions. It seems that as the self opened, the women became more in touch with their own knowing. This knowing seems to be an awareness of the self related to an inner wisdom.

Several authors have addressed the notion of an inner knowing directly (Van De Riet et al., 1980) and indirectly (Brownell et al., 1986 and Prochaska & DiClemente, 1986). The knowing has been described as a natural state of the organism in combination with aspects of the self (Van De Riet et al. 1980). A person knows what he/she knows as he/she is aware of his/her own experience. One's awareness becomes the basis for one's actions. "What is known, is the derived product of sensory input, structural formation and inner experience" (Van De Riet et al., 1980, p. 29). The sensory input, the structures of the mind and the organismic knowing all exist and awareness of them is the natural organismic state.

Self-efficacy is an indirect way of addressing knowing. A person's belief that he/she can respond effectively to a situation

by using available skills has been determined as significant in processes of change (Bandura, 1977 and Brownell et al., 1986). Self-efficacy is seen as playing a critical role in succeeding in the face of difficulties such as alcohol abuse (Prochaska & DiClemente, 1986). These findings may be applied to this study, even though the notion of self-efficacy was not reported explicitly by the participants. Several women reported "knowing" that they would get better and that they would be all right which may illustrate a sense of self-efficacy in the recovery process.

It is noteworthy that in the beginning of bulimia the participants reported feeling in control of their eating. At the same time, they did not feel powerful or in control in other aspects of their lives such as in their relationships (Barrett & Schwartz, 1987).

> The whole thing has to do with not having control over your life. The eating is the one thing I controlled . . . My husband couldn't tell me anything about my eating. That was the one thing I had control over. (Participant 3)

Eventually, the self no longer controls. "the thing about bulimia was that I was out of control, getting some control back [is what I wanted]" (Participant 5). The women wanted to be able to control their lives once again. "I wanted to get this under control" (Participant 6). It became important not to have the bulimia or other factors controlling them. The result of getting control back allowed them to open to other aspects of their lives so they could live more fully.

> There are all these doors all of a sudden open for you. It's just life, living. Getting better meant different things like not being married to someone who controlled me . . . so many things. (Participant 3)

In the process of opening, changing and recovering, the women gradually became more inner-directed and in control of themselves. As a person changes and grows, the inner voice and inner-directedness become more of a guiding force (Maslow, 1962). Change and growth occur in the direction of the individual being self-directed and in personal control of the events in his/her life. Roger called this directedness, autonomy (Klassen & Turgeon, 1981). Being self-directed has been considered as being the goal of counselling (Klassen & Turgeon, 1981) and as being the goal of living (Lowe, 1989).

Some aspects of being inner-directed include feelings of control and being assertive. Some articles on recovery processes addressed these aspects of inner-directedness and other positive traits. An article by Inbody and Ellis (1985) discussing eating disorders found characteristics of inner- directedness with anorexic and bulimic patients. All persons expressed feelings of increase control of their lives, increased self-confidence, and improved self-image. All had made gains in becoming more assertive in handling negative feelings. Wolchik et al., (1986) stated that the development of assertiveness is an important goal of their psychoeducational program in the treatment of bulimics.

Some participants in this study emphasized being honest, which appears to be an outcome of opening and being inner-directed.

> Mostly . . . my attitude has changed, I'm honest. I will say exactly what my opinion is or how I feel. My friends value that they can come to me for honesty. (Participant 4)

The honesty that accompanies openness is a factor inherent in the gestalt view of health (Van De Riet et al., 1980). The honesty is related to the need to be honest with oneself and others. Honesty is an important aspect of opening and health because each time the truth is not lived, something in the self is destroyed. "If you live your truth moment to moment, you won't be ill" (Lowe, 1989, p. 183). The expression of one's truth is a way of freeing ourselves. The present can be enjoyed when energy is available in the moment rather than tied up in holding back thoughts and feelings (Borysenko, 1987).

Maintenance Stage

Another result of opening and recovery is an openness to the body messages regarding eating and exercising. The term closest to describing this characteristic of openness is organismic-regulation whereby the individual listens to the body in determining needs (Perls et al., 1951 and Clarkson, 1989). Evidence of this openness to organismic-regulation of nutritional needs was exemplified by the women in that they ate in a healthy manner and basically what they wanted.

In the literature, reference is often made to aspects of the self such as organismic-regulation and maturing which seem to develop in relation to an opening self. For instance, the process of maturing involves an increasing awareness of the possibilities of trust in oneself for appropriate choices, in this case choosing food. Maturing is movement in the direction of self-support in the sense of responsibility for the self (Van De Riet et al., 1980).

"Opening of the self" seems related to an openness to nurturing the body with exercise. Many authors have addressed benefits which result from exercising. For instance, exercise is recognized as both a preventive and therapeutic intervention in maintaining and improving a person's health status (Paillard & Nowak, 1985). Results of exercise include reduced anxiety and improved self-concept (Simons, Solbach, Sargent & Malone, 1986). Also reported, is a close relationship between diet and physical exercise. For example, in order for the body to retain nutrients, physical activity is necessary for optimal absorption and physical strength (Liberty, 1986). Exercise resulted in improved motivation toward self-care for older adults (Paillard & Nowak, 1985). These articles pertaining to the benefits of exercise are related to the notion of improving or maintaining health for all types of persons. The articles are related to the notion of holistic health whereby attention to the body is important, as is attention to the self, for optimal health (Borysenko, 1987). These findings may be applied to this study indirectly since the participants did not address the benefits of exercise. However, they did state exercising as an aspect of maintaining health which

could imply benefits. Furthermore, one of the studies is indirectly applicable to this study because the authors address aspects of opening. The findings of Simons et al., (1986) address psychological characteristics which change as a result of exercise and perhaps opening, such as anxiety and self-concept.

A final result of opening and recovery to be addressed, is an openness to feelings and thoughts. Van De Riet et al., wrote that the healthy individual is open to the content of the inner experience of the self, such as feelings and thoughts. These findings may be applied to this study since some of the participants reported knowing that their feelings and thoughts were related to bulimic behavior which seems to involve an openness. Joseph (1987) wrote that this type of reflection can result in the self arriving at new conclusions and modifications of ways of life. Also, these findings may be applied to this study since the participant stated using behaviors other than bulimic ones, in dealing with thoughts and feelings.

Themes

The final section of this chapter addresses five themes pertinent to the understanding of the opening and recovery processes of bulimia nervosa. The themes are feedback loop, epigenesis, continued change, reframing, and treating the whole person.

Feedback Loop

A feedback loop seems to occur frequently in the experience of recovery from bulimia. For instance, an opening of the self takes place as the individual takes action, such as telling

another about the bulimia. An opening of the self occurs as a result of that telling. An opening of the self occurs as the individual takes further action, such as using strategies to help the bulimia. A further opening of the self results from taking action. Thus as one opens and acts, one opens further. As one opens and behaves in healthy ways, one opens more as a result, leading to more healthy behavior. This feedback process is a characteristic of the opening and recovery processes. The feedback loop is portrayed visually by Figure 1 illustrating the cyclical nature of the recovery process, at the end of Chapter IV.

Cybernetics has been described as the science of control and communication in the animal and the machine (Scott, 1982). von Glasersfeld (1979) adopted a cybernetic attitude in developing ideas on feedback and self-regulation. The author stated that an individual organizes himself/herself in a circular arrangement of feedback loops. Behavior occurs as a result of feedback loops. Furthermore, learning occurs as a result of disturbances where an individual will modify behavior in order to reduce the disturbance.

In relation to opening and recovery, it appears that von Glasersfeld's (1979) ideas of feedback apply. The circular organization used by the self is evident by opening of the self leading to healthy behaviors and how the healthy behavior leads to further opening. Also, it seems that learning occurs not only through disturbances but also consequences. For instance, the opening of the self which occurs in seeking treatment results in more opening. The consequence is that the individual feels better. Further opening takes place which leads individuals to

engage in further activities, such as informal factors. The consequence is that the individual feels even better. Further opening occurs, and so on.

Epigenesis

The stages of contemplation, action, recovered and maintenance are each clearly delineated. Each stage unfolds in a particular manner and in a particular order. In addition, it appears that the stages are present in some form throughout the recovery process and perhaps life. For example, in the recovered and maintenance stages, there are times when an individual contemplates change and then takes action, such as during relapse. In daily life, an individual may realize that too much sugar is being consumed (Contemplation Stage) and decides to take action, such as reducing sugar intake (Action Stage). Also, there may be a realization that exercise is needed in order to nurture the body and the self (Contemplation Stage). Thus, action is taken, such as exercising (Action Stage). The individual feels better (Recovered Stage) and may maintain the changes (Maintenance Stage).

Crain (1980) wrote that Erikson's (1950) account of the Eight Stages of Life demonstrated that each stage is present in some form throughout life. Evans (1981) wrote that each of the stages add something specific to all later ones and an ensemble is made out of the earlier stages. Erikson developed the term epigenesis to describe these processes where "epi means upon and genesis, emergence" (Evans, 1981, p. 21).

Both of these aspects of epigenesis seem to apply to the experience of opening and recovery. The stages may occur in some form throughout life. Also, each stage seems to add something specific to later ones. For instance, at each stage an opening of the self occurs which is added to the following stages. The ensemble results in an open self, recovered from bulimia.

Continued Change

It appears that this process of opening the self and recovery from bulimia can become a direction of continued healthy development. In this study, two of the seven participants expressed a desire to continue making changes and growing following recovery.

Several authors have addressed this notion of continued change. For instance, Daley (1989) wrote that recovery from alcohol and substance abuse ends with personal growth and that there is a need for a daily lifelong program of recovery. Brownell et al., (1986) stated that in order to continue abstinence from smoking and alcohol abuse, a model of lifelong treatment is necessary. DiClemente and Prochaska (1982) and Van De Riet et al., (1980) wrote that continued change and growth is conceptualized as a way of life.

These findings apply to the study since two of the participants stated continued change. It appears that a conscious desire to continue growing is a personal decision and not a necessary aspect of recovery from bulimia. However, the other participants may continue growing as a result of maintaining a state of being recovered and healthy. As said earlier, it is a

natural state of the organism to move towards wholeness and growth (Borysenko, 1987).

Reframing

Reframing could apply to bulimia in three ways. First, bulimia can be reframed as a developmental process. This has the advantage of viewing the dis-ease as a potential for opening and growth. Furthermore, framing bulimia in this way has the potential of easing the stigma attached to the eating disorder. The stigma is evident in that it is kept secret. Herzog called it the secretive syndrome (1982). It may be therapeutic for people if they could consider their situation as a kind of potential for opening and growth while in dis-ease.

Second, bulimia could be reframed as providing signals that something needs to be learned. For instance, the dis-ease may be trying to encourage the individual to be less outer-directed and more inner-directed.

Third, reframing could be used in describing the process of treatment and recovery. Stevens and Salisbury (1984) wrote that bulimics are rarely cured as a result of treatment, most experience a reduction of symptoms. It is proposed that this notion be reframed as: most bulimics experience a reduction of symptoms during the recovery process as a result of treatment. Being cured may or may not occur due to treatment yet recovery implies eventual cure and healing of bulimia.

Reframing meanings is most popularly used in Neurolinguistic Programming (NLP) (Borysenko, 1987). The purpose of the technique is to frame a negative perception into a positive one. Illness,

seen negatively, promotes helplessness and self-pity, which drain away creative power. Illness or dis-ease can be seen in a positive way, for example, by trying to teach us something (Borysenko, 1987). Jourard (1971) and Jourard and Landsman (1980) wrote that illness is a way to express a protest against a way of life that does not support wellness. Again, the importance lies in refraining illness as expressing a message to be listened to.

Treating the Whole Person

The opening of the self occurs as a result of treating the whole person, and not just the symptoms of bulimia. For instance, as the women in this study focused on work, friends and activities such as bike riding, they experienced an opening of the self and a reduction of their bulimic symptoms. This may be explained by the notion of holism.

> The organism is a whole . . . you can approach the total organism from different aspects . . . any change in any sphere [biochemical, behavioristic, experimental, etc.] produces a change in every other corresponding aspect (Perls, 1972, p. 167-168).

The notion of treating various aspects of the individual and thereby creating change in the bulimia occurs because the organism is a whole. Focus on external factors, results in internal changes, which in turn affects the bulimic patterns. A participant reported that when she got work, she felt a sense of purpose and as a result her bulimia subsided. Thus, the notion of holism is an important concept in the treatment of bulimia since each part affects every other related part.

Summary

The theory of recovery from bulimia addresses several concepts not found in the secondary literature review, such as the significance of telling, characteristics of the bulimia subsiding and changed attitudes related to eating. It is evident that these concepts pertain to characteristics of a qualitative nature. The concepts emerged because of the qualitative interviewing techinque. Since the articles on recovery processes were of a quantitative nature, the lack of qualitative data related to these areas is understandable.

As the self becomes closed and bulimic, the inner wisdom and organismic-regulation of the self become progressively less available. In the gradual process of opening, demonstrated by the contemplation and action stages, the self eventually develops the characteristics of inner-directedness and self-regulation. These characteristics result in healthy choosing, control knowing and honesty as demonstrated by the recovered and maintenance stages.

In the process of opening and recovering, five themes emerge as pertinent to the processes. First, the feedback loop illustrates how healthy behavior can build on itself. Second, epigenesis demonstrates how the four stages are cumulative and present to some degree throughout life. Third, continued change shows how development is a continual process. Fourth, reframing illustrates the benefit of viewing circumstances in a positive manner. Lastly, treating the whole person exemplifies how making a change in one area of life affects the whole self.

CHAPTER VIII

CONCLUSIONS AND IMPLICATIONS

The information gained in this study of recovery contributes to the understanding of overcoming the dysfunctional behavior of bulimia nervosa. Conclusions and implications for clinical practice and research are addressed in this section. Also, implications for the researcher in clinical practice is examined. First, the researcher's presuppositions are reviewed.

Reexamination of Presuppositions

Earlier potential influences of the researcher's background and frame of reference in the experience of recovery from bulimia nervosa were discussed (see pages 89-90). The first presupposition of the study which needs to be examined is the exclusion of the codes from the pilot study. The pilot study codes that emerged could contaminate an openness to the data in the main study. Thus, the researcher excluded the pilot study codes from the analysis of data pertaining to the main study. The final basic psychosocial process and most of the theoretical and substantive codes were considerably different then the emergent categories of the pilot study. Some theoretical codes emerged as similar, for example, personal resolve, stage, cyclical and temporal factor. Some substantive codes which were the same were realizing and relapsing. All the remaining codes for the final study were different. Thus, it appears that the exclusion of the pilot study codes permitted codes to emerge pertinent to the main study.

The second presupposition was the researcher's notion of self-awareness being a factor involved in the recovery process.

Even though self-awareness was significant in alleviating the researcher's disordered eating, this may not have been the case for other individuals. The researcher considered that self-awareness may have nothing to do with the experiences seen as significant by the women. Out of the seven women interviewed, only one woman referred to terms related to self-awareness. It seemed, however, that awareness was a factor involved in the recovery process even though it was not reported explicitly. For instance, in the contemplation stage the women realized their behavior. Awareness was the closest concept in the literature to describe realizing. This supported the researcher's bias that awareness is significant to the recovery process.

The third presupposition was that there would be some kind of internal change involved in the process of recovery. An internal change, such as feeling better about oneself, would result in the bulimia subsiding. Participants reported both internal and external change as being significant in their recovery. The researcher's presupposition that an internal change is involved in the recovery process, was supported.

Based upon the researcher's previous experience with bulimia nervosa and disordered eating, it was presupposed that persons intentions to change through formal or informal treatment strategies would be an important factor in recovery. However, this notion was incorrect in some cases. Several women recovered by orienting themselves to new experiences, such as job, pregnancy or relocation. These experiences incorporated actions that were not directly an intention to overcome bulimia, even though they were significant in the recovery process. The intention to

recover was found to be insignificant in some cases. The researcher's presupposition was not supported.

The final presupposition was the researcher's belief that experiences involving other aspects of experience and not the bulimia per se, would result in the bulimia subsiding. Participants reported many aspects not related directly to the bulimia, as being helpful in alleviating symptoms. Thus, experiences involving the whole person were found directly beneficial to the recovery process. The presupposition was supported.

Conclusions

The experience of recovery from bulimia nervosa was described by seven women. The experiences seen as most significant involved both psychological and social variables. The basic psychosocial process (BPSP) which emerged from the descriptions of the experience of recovery was "opening the self". This process evolved into five theoretical codes and twelve substantive codes. The theoretical codes are implicitly present in varying degrees throughout the BPSP theory. They were self, personal resolve, stages, temporal factor and cyclical pattern. The BPSP theory emerged as a four stage process. The stages were contemplation, action, recovered and maintenance. The twelve substantive codes and their properties made-up the BPSP four stage theory.

"Opening the self" appeared throughout the theory of recovery with nuances of meaning. For instance, in the contemplation stage, the self began to open in realizing a problem existed and in contemplating change. In the action stage, the

opening of the self was characterized by not keeping the behavior secret by taking some kind of action. In the recovered stage, the opening of the self can be described as the self expanded. In the maintenance stage, the opening of the self can be characterized as being open in one's heart and mind in maintaining health and continuing to move towards life.

"Opening the self" appeared throughout the theory of recovery in varying degrees. For example, it was most evident in the 4 stages of recovery. It was less evident in the temporal factor and cyclical pattern.

This qualitative research illuminates actual processes of recovery from bulimia. It has examined the actual experience of what occurred for bulimics who have recovered and stayed well. The most significant findings are: first, that "opening the self" is the basic psychosocial process of recovery from bulimia; second, that the process of recovery involves an interaction and combination of psychological and social variables; third, that the 4 stages of the theory describe the phases of the experience of recovery; fourth, that opening the self results in self-directedness; fifth, that opening of the self and recovery can occur by engaging in informal factors only and sixth, that recovery occurred unintentionally, followed by a choosing to continue healthy behavior. Finally, the BPSP theory of recovery from bulimia adds a new dimension to the research literature on bulimia. No theories of recovery demonstrating the experience or process of change in recovering from bulimia nervosa were found in the literature.

"Opening the self" has been poorly researched in the literature on recovery in other health related areas. It seems

this concept emerged from this study because of the qualitative approach. In quantitative studies "opening the self" is not dealt with directly yet it seems to be implied in some cases. Also, related aspects, such as characteristics developed from the self opening, are referred to in the literature.

There may be some gaps in the theory of recovery from bulimia. For instance, no men were interviewed for the study. Ideally men with similar characteristics need to be interviewed. The theory of recovery from bulimia may not account for processes in corresponding males.

Certain areas pertaining to the BPSP theory of recovery, remain to be studied. For instance, recovered bulimics with previous drug and alcohol problems or anorexia need to be studied in order to further develop the theory of recovery. The theory needs to encompass different types of bulimics. Family members' perspectives regarding the individual's process of recovery need to be addressed. The information of these people observing the process may add to the theory. Finally, friends and therapists' views could expand the theory of recovery. They would be involved with the individual in a different manner than family members and may add a different dimension.

The use of grounded theory would be beneficial for continued research as it is suitable for purposes of modification and expansion of theories. The experiences of various recovered bulimics, family members, friends and therapists could be studied using grounded theory.

Implications

Implications for Clinical Practice

The potential applicability of the theory of recovery exists in several ways. First, professionals working in the field of treating bulimics would benefit in using the theory to compare with bulimics in the process of recovery. They could estimate more clearly where their clients are in their recovery process. Second, bulimics reading the theory may be enlightened from knowing about others' experiences of recovery. This may lead to change. Third, family of the bulimic would gain greater understanding of the syndrome from reading the theory. Finally, the theory of recovery could be used as a psychoeducational model for prevention. For example, the theory of recovery could be presented to high school students or the general public, informing them of the process bulimics experience in recovering from bulimia.

Implications for Research

The theory of recovery from bulimia can be used as a springboard for further studies in the areas of addiction and recovery. For instance, the theory of recovery could be used in examining recovery processes of drug addicts or alcoholics. The theory could be modified accordingly.

The research model used in the study of recovery from bulimia could be used to study people who have recovered from other addictive disorders. The research model could also be used in examining people who have recovered from other experiences, such as divorce, miscarriage, cancer or heart attack.

Further research could involve quantification. For example, the theory of recovery could be distributed among professionals, bulimics, or recovered bulimics. A questionnaire assessing reader's feedback could be included. Then, the results of the questionnaire could be quantified.

Implications for the Researcher

The theory of recovery provides a conceptual framework which I can use in my clinical work with bulimics. I understand recovery as being a process. This knowledge allows me to have greater empathy and compassion. This allows me to be empowered as a clinician in knowing and understanding the recovery process. Also, knowing the number of people who recover using informal factors only and those who use informal factors as well as formal treatment, leads me to a greater understanding of my role as a clinician. My role as a clinician is important, but is only one factor among many in the recovery from bulimia. I see myself as encouraging clients in the action stage, for example, to use informal factors, such as being with friends and becoming generally more active in their lives.

In terms of research, I would like to continue interviewing recovered bulimics, for instance, to determine whether the theory of recovery applies to all types of bulimics, such as those with a history of anorexia, drug abuse and alcoholism. I am interested in examining the theory in relation to other health related problems such as alcoholism and drug addiction.

REFERENCES

Abraham, S. F., Mira M., & Llewellyn-Jones, D. (1983). Bulimia: A study of outcome. *International Journal of Eating Disorder, 2*, 175-180.

Achterberg, J. *Imagery in Healing: Shamanism and Modern Medicine.* Boston: New Science Library

American Psychiatric Association (1980). *Diagnostic & Statistical Manual of Mental Disorders III.* Washington, D.C.: APA.

American Psychiatric Association (1986). *Diagnostic & Statistical Manual of Mental Disorders III Revised* (4th ed.). Washington, D.C.: APA.

Bachmann, M. & Röhr, H. P. (1983). A speculative illness model of over-eating and anorexia nervosa. *Psychological Reports, 53*, 831-838.

Bandura, A. (1962). Social learning through imitation. In W. C. Crain *Theories of Development: Concepts and Applications.* U.S.A.: Prentice-Hall, Inc.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. Psychological Review, 84, 191-215. In: J. Overholser & S. Beck. Assessing generalization of treatment effects and self-efficacy in the modification of eating styles in obese children. *Addictive Behaviors, 10*, 145-152.

Barrett, M. J. & Schwartz, R. (1987). Couple therapy for bulimia. *Family Therapy Collections, 20*, 25-39.

Barrick, M. R. & Alexander, R. A. (1987). A review of quality circle efficacy and the existence of positive findings bias. *Personnel Psychology, 40*, 579-592.

Boring, E. G. (1950). A history of experimental psychology (2nd ed.). New York: Appleton - Century - Crofts. In: A. Giorgi (1970) *Psychology As a Human Science.* New York, Harper & Row.

Borysenko, J. (1987). *Minding the Body, Mending the Mind.* U.S.A.: Library of Congress.

Boskind-Lodahl, M. (December, 1983). Cinderella's Stepsisters: A Feminist perspective on anorexia nervosa on bulimia. *Personnel & Guidance Journal, 62*, 234-239.

Brammer, L. M. (1984). Counseling theory and the older adult. *The Counseling Psychologist, 12*, 29-36.

Brone, R. J. & Fisher, C. B. (1988). Determinants of adolescent obesity: a comparison with anorexia nervosa. *Adolescence, 23*, 155-169.

Brown, G. I. (1977). *Human Teaching for Human Learning: An Introduction to Confluent Education*. Tennessee: Penguin Books Ltd.

Brownell, K. D., Marlatt, G. A., Lichtenstein, E. & Wilson, G. T. (1986). Understanding and preventing relapse. *American Psychologist, 41*, 765-782.

Bruch, H. (1973). *Eating Disorders - Obesity, Anorexia, and the Person Within*. New York: Basic Books.

Carter, J. A. & Duncan, P. A. (1984). Binge-eating and vomiting: a survery of a high school population. *Psychology in the schools, 21*, 198-203.

Carter, J. A., Iyriboz, Y. & Greenockle, M. S. (1986). Bulimia: some physiological considerations. *College Health, 35*, 139-140.

Cauwels, J. M. (1983). *Bulimia - The Binge-Purge Compulsion*. U.S.A.: Library of Congress Cataloguing.

Chenitz, W. C. & Swanson, J. M. (1986). *From Practice to Grounded Theory*. California: Addison-Wesley Publishing Company.

Chiodo, J. (1987). Invited case transcript bulimia: an individual behaviorial analysis. *Journal of Behaviorial and Experiential Psychiatry, 18*, 41-49.

Clarkson, P. (1989). *Gestalt Counseling in Action*. Great Britain. Sage Publications, Ltd.

Colaizzi, P. G. (1978). Psychological research as the phenomenologist views it. In: R. S. Valle & M. King (Eds.). *Existential - Phenomenological Alternatives for Psychology*. New York: Oxford University Press.

Connors, M. E., Johnson, C. L., Stuckey, M. K. (1984). *American Journal of Psychiatry, December, 141*, 1512-1516.

Cooper, P. I. & Fairburn, C. G. (1983). Binge-eating and self-induced vomiting in the community - a preliminary study. *British Journal of Psychiatry, 142*, 139-144.

Cooper, P. J. & Fairburn, C. G. (1984). Cognitive behavior therapy for anorexia nervosa: preliminary findings. *Journal of Psychosomatic Research, 28*, 493-499.

Cooper, Z. & Fairburn, C. (1987). The Eating Disorder Examination: A semi-structured interview for the assessment of the specific psychopathology of eating disorders. *International Journal of Eating Disorders, 6*, 1-8.

Crain, W. C. (1980). *Theories of Development: Concepts and Applications*. U.S.A.: Prentice-Hall, Inc.

Crisp, A. H. (1965). Some aspects of the evolution presentation and follow-up of anorexia nervosa. Proceedings of the Royal Society of Medicine, 58, 814-820. In: J. Polivy and C. Herman. Diagnosis and treatment of normal eating. *Journal of Consulting and Clinical Psychology. 5*, 635-644.

Daley, D. C. (1989). *Relapse Prevention*. U.S.A.: Tab Books, Inc.

Daniels, J. S. (1984). The pathogenesis of obesity. *Psychiatric Clinics of North America, 7*, 335-347.

Das, A. K. (1989). Beyond self-actualization. *International Journal for the Advancement of Counseling, 12*, 13-27.

DiClemente, C. C. (1981). Self-efficacy and smoking cessation maintenance: a preliminary report. *Cognitive Therapy and Research, 5*, 175-187.

DiClemente, C. C. & Prochaska, J. O. (1982). Self-change and therapy change of smoking behavior: A comparison of processes of change in cessation and maintenance. *Addictive Behaviors, 7*, 133-142.

DiClemente, C. C. & Prochaska, J. O. (1985). Processes and stages of self-change: Coping and competence in smoking behavior change. In S. Shiffman & T. A. Wills (Eds.). *Coping and substance Abuse*. Florida: Academic Press, Inc., U.S.A.

Dinkmeyer, D. & Sherman, R. (1989). *Brief Adlerian Family Therapy*. *Individual Psychology, 45*, 148-158.

Doerr, B. T. & Hutchins, E. B. (1981). Health risk appraisal: process, problems, and prospects for nursing practive and research. *Nursing Research, 30*, 299-306.

Dykens, E. M. & Gerrard, M. (1986). Psychological profiles of purging bulimics, repeat dieters and controls. *Journal of Consulting and Clinical Psychology, 54*, 283-288.

Edwards, N. B., Simmons, R. C., Rosenthal, T. L., Hoon, P. W. et al. (1988). Doxepin in the treatment of nicotine withdrawal. *Psychosomatics. 29*, 203-206.

Engel, K. & Wilms, H. (1986). Therapy motivation in anorexia nervosa: theory and first empirical results. *Psychotherapy and Psychosomatics, 46*, 161-170.

English H. & English, A. (1958). *A Comprehensive Dictionary of Psychological and Psychoanalytic Terms.* New York: David McKay Co., Inc.

Erikson, E. H. (1950). Childhood and society. New York, W. N. Norton & Co. Inc. In: W. C. Crain. (1980) *Theories of Development: Concepts and Applications.* U.S.A.: Prentice-Hall, Inc.

Evans, R. I. (1981). *Dialogue with Gordon Allport.* New York: Praeger Publishing.

Evans, R. I. (1981). *Dialogue with Erik Erikson.* New York: Praeger Publishing.

Fadiman, J. & Frazer, R. (1976). *Personality and Personal Growth.* New York: Harper & Row Publishers, Inc.

Fairburn, C. G. (1981). A cognitive approach to the management of bulimia. *Psychological Medicine, 11*, 707-711.

Fairburn, C. G. & Cooper, P. J. (1984). The clinical features of bulimia nervosa. *British Journal Psychiatry, 144*, 238-246.

Fairburn, C. G. & Cooper, P. J. (1984). Binge eating, self-induced vomiting and laxative abuse: A community study. *Psychological Medicine, 14*, 401-410.

Fairburn, C. G. & Kirk, J., O'Connor, M., Anastasiades, P. & Cooper, P. J. (1987). Prognostic factors in bulimia nervosa. *British Journal of Clinical Psychology, 26*, 223-224.

Filstead, W. I., Parella, D. P. & Ebbitt, J. (1987). High risk situations for engaging in substance abuse and binge-eating behaviors. *Journal of Studies on Alcohol, 49*, 136-141.

France, M. H., McDowell, C. & Knowles, D. (1984). Understanding and coping with loneliness. *School Counselor, 32*, 11-16.

Freeman, C. P. L., Barry, F., Dunkeld-Turnbull, J. & Henderson, A. (1988). Controlled trial of psychotherapy for bulimia nervosa. *British Medical Journal*, February, *296*, 521-555.

Funk & Wagnall's Standard Dictionary (1980). Lippincott & Crowell, Publisher, U.S.A.

Garner, D. M. & Bemis, K. M. (1982). A cognitive-behavioral approach to anorexia nervosa. *Cognitive Therapy and Research, 6*, 123-150.

Garner, D. M., Fairburn, C. G., & Davis, R. (1987). Cognitive-behaviorial treatment of bulimia nervosa. *Behavior Modification, 11*, 398-431.

Garner, D. M., Garfinkel, P. E. & O'Shaughnessy, M. (1985). The validity of the distinction between bulimia with and without anorexia nervosa. *American Journal of Psychiatry, 142*, 581-587.

Giorgi, A. (1970). *Psychology As a Human Science*. New York: Harper & Row.

Glaser, B. G. (1978). *Theoretical Sensitivity*. San Francisco: The Sociology Press.

Glaser, B. G. & Strauss, A. L. (1967). *Discovery of Grounded Theory*. Illinois: Aldine Publishing Company.

Gold, R. L. (1958). Roles in sociological field observations. *Social Forces, 36*, 217-223.

Goodsitt, A. (1983). Self-regulatory disturbances in eating disorders. *International Journal of Eating Disorders, 2*, 51-60.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *ERIC/ECTJ. Annual Review Paper, 29*, 75-91.

Gunn, R. C. (1986). Reactions to withdrawal symptoms and success in smoking cessation clinics. *Addictive Behavior, 11*, 49-53.

Gwirtsman, H. E., Roy-Byrne, P. & Yager, J., Gerner, R. H. (1983). Neuroendocrine abnormalities in bulimia. *American Journal of Psychiatry, 140*, 559-563.

Harré, R. & Lamb, R. (1983). *The Encyclopedic Dictionary of Psychology*. England: Basil Blackwell Publisher Ltd.

Harwood, I. H. (1983). The application of self-psychology concepts to group psychotherapy. *International Journal of Group Psychotherapy, 33*, 469-487.

Hatsukami, D., Eckert, E., Mitchell, J. E. & Pyle, R. (1984). Affective disorder and substance abuse in women with bulimia. *Psychological Medicine, 14*, 701-704.

Hatsukami, D., Owen, P., Pyle, R. & Mitchell, J. (1982). Similarities and differences on the MMPI between women with bulimia and women with alcohol or drug abuse problems. *Addictive Behavior, 7*, 435-439.

Herzog, D. B. (1982). Bulimia: The secretive syndrome. *Psychosomatics, 23*, 481-484.

Holme, R. (1972). *Psychology Today, An Introduction*, U.S.A.: Communications Research Machines Inc.

Hooker, D. & Convisser, E. (1983). Women's eating problems: An Analysis of a coping mechanism. *Personnel & Guidance Journal, December, 62*, 236-239.

Inbody, D. R. & Ellis, J. J. (1985). Group therapy with anorexic and bulimic patients: implications for therapeutic intervention. *American Journal of Psychotherapy, 39*, 411-420.

Jackson, S. (1986). Therapeutic change and anorexia nervosa: views of a family and therapist. *Australia and New Zealand Journal of Family Therapy, 7*, 69-74.

Johnson, C., Connors, M. & Stuckey, M. (1981). Short term group treatment of bulimia. *International Journal of Eating Disorders, Summer, 2*, 199-208.

Johnson, C. L., Stuckey, M. K., Lewis, L. D. & Schwartz, D. M. (1982). Bulimia: A descriptive survey of 316 cases. *International Journal of Eating Disorders, 2*, 3-16.

Joseph, E. D. (1987). The Consciousness of being conscious. *Journal of the American Psychoanalytic Association, 35*, 5-22.

Jouard, S. M. (1971). *The Transparent Self*. Canada: Van Norstrand Reinhold Company.

Jouard, S. M. & Landsman, T. (1980). *Healthy Personality*. (4th Ed.). U.S.A.: MacMillan Publishing Co., Inc.

Katzman, M. A. & Wolchik, S. A. (1984). Bulimia and binge eating in college women: A comparison of personality and behavioral characteristics. *Journal of Consulting and Clinical Psychology, 52*, 423-428.

Katzman, M. A., Wolchik, S. A., & Braver, S. L. (1984). The prevalence of pregnant binge eating and bulimia in a nonclinical college sample. *International Journal of Eating Disorders, 51*, 53-62.

Killen, J. K., Taylor, C. B., Telch, M. J., Saylor, K. E., Maron, D. J. & Robinson, T. N. (1987). Evidence for an alcohol-stress link among normal weight adolescents reporting purging behavior. *International Journal of Eating Disorders, 6*, 349-356.

Klassen, D. & Turgeon, P. (1981). The effect of Rogerian counseling conditions on locus of control. *International Journal for the Advancement of Counseling, 4*, 89-99.

Kluback, W. (1956). Wilhelm Dilthey's philosophy of history. New York: Columbia. In: A. Giorgi (1970) *Psychology As a Human Science*. New York: Harpers & Row.

Kus, J. (1986). From grounded theory to clinical practice: cases from gay studies research. In: W. C. Chenitz and J. M. Swanson (1986). *From Practice to Grounded Theory*. California: Addison-Wesley Publishing Company.

Lacey, J. H. (1984). Moderation of bulimia. *Journal of Psychosomatic Research, 28*, 397-402.

Larocca, F. E. (1984). An inpatient model for the treatment of eating disorders. *Psychiatric Clinics of North America, 7*, 287-298.

Lawrie, J. (1982). Training. *Personnel Journal, 61*, 820-822.

LeCompte, M. D. & Goetz, J. P. (1982). Problems of reliability and validity in ethnographic research. *Review of Educational Research, 52*, 31-60.

Levenkron, S. (1982). *Treating and Overcoming Anorexia Nervosa*. New York: Warner Books Inc.

Lewis, P. (1987). Therapeutic change in groups: An interactional perspective. *Small Group Behavior, 18*, 548-556.

Liberty, L. H. (1986). Nutritional awareness for rehabilitation counselors. *Journal of Applied Rehabilitation Counseling, 18*, 21-24.

Lowe, P. G. (1989). *The Experiment Is Over*. New York: Roximillion Publications Corporation.

Lowry, R. J. (Ed.) (1982). *The Journals of Abraham Maslow*. U.S.A.: The Lewis Publishing Company.

Lowen, A. (1981). *Bioenergetics*. Pensylvania: Offset Paperback Manufactures, Inc.

Maddux, J. E. & Rogers, R. W. (1983). Protection motivation and self-efficacy: a revised theory of fear appeals and attitude change. *Journal of Experimental Social Psychology, 19*, 469-479.

Malenbaum, R., Herzog, D., Eisenthal, S. & Wyshak, G. (1988). Overeaters Anonymous: Impact on bulimia. *International Journal of Eating Disorders, 7*, 139-143.

Maslow, A. (1966). *The Psychology of Science.* Chicago: Henry Regnery Co.

Maslow, A. (1962). Toward a Psychology of Being (2nd ed.). Princeton: D. Van Nostrand, In: W. C. Crain. *Theories of Development*. Prentice-Hall, N.J.

May, R., Angel, E. and Ellenberger, H. F. (Eds.) (1958). Existence: A new dimension in psychiatry and psychology. New York: Basic Books In: A. Giorgi (1970) *Psychology As A Human Science*. New York: Harpers & Row.

McCargar, L. J., Clandinin, M. T., Fawcett, D. M. & Johnston, J. L. (1988). Short-term changes in energy intake and serum insulin neutral amino acids, and urinary catecholamine excretion in women. *American Journal of Clinical Nutrition*, 932-941.

Mead, G. H. (1934). *Mind, Self & Society*. Chicago: The University of Chicago Press.

Merleau-Ponty, M. (1964). Phenomenology and the science of man. In: A. Giorgi (1970). *Psychology As a Human Science*. New York: Harper & Row.

Merrill, C. A., Mines, R. A., & Starkey, R. (1987). The Premature dropout in the group treatment of bulimia. *International Journal of Eating Disorders, 6*, 293-300.

Meyers, L. S. & Wong, D. T., (1988). Validation of a new test of locus of control index. *Educational and Psychological Measurement, 48*, 753-761.

Mitchell, J. E. & Pyle, R. L. (1982). The bulimia syndrome in normal weight individuals: A review. *International Journal of Eating Disorders, Winter*, 61-73.

Morin, C. M., Winter, B., Besalel, V. A. & Azrin, N. H. (1987). Bulimia: A case illustration of the superiority of behavioral over cognitive treatment. *Journal of Behavioral and Experiential Psychiatry, 18*, 165-169.

Morse, J. M. (1989). Strategies for sampling. In: J. M. Morse (Ed.) *Qualitative Nursing Research*. Rockville: Aspen Publishers.

Orbach, S. (1978). *Fat is a Feminist Issue.* New York: Paddington Press.

Orbach, S. (1984). *Fat is a Feminist Issue II.* New York: Berkley Publishing Group.

Ordman, A. M. & Kirschenbaum, D. S. (1985). Cognitive behavioral therapy for bulimia: an initial outcome study. *Journal of Consulting and Clinical Psychology, 53,* 305-313.

Ortega, D. F., Waranch, H. R., Maldonado, A. J. & Hubbard, F. A. (1987). A comparative analysis of self-report measures of bulimia. *International Journal of Eating Disorders, 6,* 301-311.

Overholser, J. & Beck, S. (1985). Assessing generalization of treatment effects and self-efficacy in the modification of eating styles in obese children. *Addictive Behaviors, 10,* 145-152.

Ozer, M. N. (Ed.) (1979). *A Cybernetic Approach to the Assessment of Children: Toward a More Humane Use of Human Beings.* U.S.A.: Westview Press, Inc.

Paillard, M & Nowak, K. B. (1985). Use exercise to help older adults. *Journal of Gerontological Nursing, 11,* 26-39.

Parloff, M. B. (1984). Psychotherapy research and its incredible credibility crisis. *Clinical Psychology Review, 4,* 95-109.

Pennington, S. (1981). *Living or Dying: An Investigation of the Balance Point.* University of Toronto: unpublished dissertation.

Perls, F. S., Hefferline, R. F. & Goodman, P. V. (1955). *Gestalt Therapy.* New York: Crown Publishers, Inc.

Perls, F. S. (1969). *Gestalt Therapy Verbatim.* Lafayette California: The Red People Press.

Perls, F. S. (1972). *In and out the Garbage Pail.* New York: Bantamm Books.

Perri, M. G. (1985). Self-change strategies for the control of smoking, obesity, and problem drinking. In: S. Shiffman & T. A. Wills (Eds). *Coping and Substance Abuse.* Academic Press, U.S.A.

Ploog, D. W. & Pirke, K. M. (1987). Psycholsiology of anorexia nervosa. *Psychological Medicine, 17,* 843-859.

Polanyi, M. (1958). Personal knowledge. New York: Harper & Row. In: E. G. Guba (1981). Criteria for assessing the trust-worthiness of naturalistic inquiries - *ERIC/ECTJ Annual Review Paper, 29*, 75-91.

Polivy, J., & Herman, C. P. (1987). Diagnosis and treatment of normal eating. *Journal of Consulting and Clinical Psychology, 55*, 635-644.

Pope, H. G. & Hudson, G. I. (1984). *New Hope for Binge Eaters*. New York: Harper & Row.

Pope, H. G., Hudson, J. I. & Jonas, J. M. (1986). Brief communication, bulimia in men: A series of fifteen cases. *The Journal of Nervous and Mental Disease, 174*, 117-119.

Prochaska, J. O. & DiClemente, C. C. (1986). Toward a comprehensive model of change. In: A. S. Bellack & M. Hersen (Eds). *Treating Addictive Behaviors*. Plenum Press, New York.

Prochaska, J. O. & DiClemente, C. C. (1985). Common processes of self-change in smoking, weight control, and psychological distress. In: S. Shiffman & T. A. Wills (Eds). *Coping and Substance Use*. Academic Press, U.S.A.

Pyle, R. L., Mitchell, J. E. & Eckert, E. D. (1981). Bulimia: A report of 34 cases. *Journal of Clinical Psychiatry, 42*, 60-64.

Pyle, R. L., Mitchell, J. E., Eckert, E. D., Halvorson, P. A., Neuman, P. A. & Goff, G. M. (1983). The incidence of bulimia in freshmen college students. *International Journal of Eating Disorders, 2*, 75-85.

Reber, A. S. (1985). *The Penguin Dictionary of Psychology*. England: Penguin Books Ltd.

Reiser, L. W. (1988). Compulsive eating: obesity and related phenomena. *Journal of the American Psychoanalytic Association, 36*, 163-171.

Rennie D. L., Phillips, J. R., Quartaro, J. R. (1988). Grounded theory: A promising approach to conceptualization in psychology? *Canadian Psychology, 29*, 139-150.

Rogers, C. R. (1987). The underlying theory: drawn from experience with individuals and groups. *Counseling and Values, 32*, 39-46.

Rosenthal, R. (1986). *Experimenter Effects in Behaviorial Research*. New York: John Wiley & Sons.

Roth, G. (1984). *Breaking Free from Compulsive Eating*. New York: Bobbs-Merrill Co., Inc.

Roy-Byrne, P., Lee-Brenner, K. & Yager, I. (1984). Group therapy for bulimia: A year's experience. *International Journal of Eating Disorders, 3*, 97-116.

Russell, G. (1979). Bulimia nervosa: An ominous variant of anorexia nervosa. *Psychological Medicine, 9*, 429-448.

Russell, G. F. M., Szmukler, G. I., Dare, C. & Eisler, I. (1987). An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Archives General Psychiatry, 44*, 1047-1056.

Salner, M. (1986). Validity in human science research. *Saybrook Review, 6*, 107-130.

Schneider, J. A. & Agras, W. S. (1987). Bulimia in Males: A matched comparison with females. *International Journal of Eating Disorders, 6*, 735-742.

Scott, B. (1987). Human systems, communication and Educational Psychology. *Educational Psychology, 3*, 4-15.

Scott, D. W. (1983). Alcohol and food abuse: Some comparisons. *British Journal of Addiction, 78*, 339-349.

Sherin, K. S. (1983). Motivating lifestyle change. *The Journal of Family Practice, 16*, 183-191.

Simons, A., Solbach, P., Sargent, J., Malone, L. (1986). A wellness program in the treatment of headaches. *Headache, 26*, 343-352.

Sohlberg, S., Rosmark, B., Norring, C. & Holmgren, S. (1987). Two year outcome in anorexia nervosa/bulimia: A controlled study of an eating control program with psychoanalytically oriented psychotherapy. *International Journal of Eating Disorders, 6*, 243-255.

Stevens, E. V. & Salisbury, J. D. (1984). Group therapy for bulimic adults. *American Journal of Orthopsychiatry, January, 54*, 156-161.

Stuck, M. F. & Glassner, B. (1985). The transition from drug use and crime to noninvolvement: A case study. *Adolescence, 20*, 669-679.

Swift, W. J., Ritholz, M., Kalin, N. H. & Kaslow, N. (1987). A follow-up study of thirty hospitalized bulimics. *Psychosomatic Medicine, 49*, 45-55.

Sykes, J. B. (1982). *The Oxford Concise Dictionary*. New York: Oxford University Press.

Theander, S. (1985). Outcome and prognosis in anorexia nervosa. *Journal of Psychiatric Research, 19*, 493-508.

Van De Riet, V., Korb, M. P. & Gorrell, I. J. (1980). *Gestalt Therapy. An Introduction.* U.S.A.: Pergamon Press Inc.

von Glasersfeld, E. (1979). Cybernetics, experience and the concept of self. In: M. N. Ozer. (1979). *A Cybernetic Approach to the Assessment of Children: Toward a Humane Use of Human Beings.* U.S.A.: Westview Press, Inc.

Wardle, J. (1987). Compulsive eating and dietary restraint. *British Journal of Clinical Psychology, 26*, 47-55.

Watzlawick, P., Weakland, R. & Fisch, J. (1982). Principles of problem formation and problem resolution. In: A. O. Weiss Dealing with the process of change. *The Journal of Contemporary Social Work, December*, 607-614.

Weiss, A. A. (1982). Dealing with the process of change. *The Journal of Contemporary Social Work, December*, 607-614.

Westermeyer, J. (1989). Nontreatment factors affecting treatment outcome in substance abuse. *American Journal of Drug and Alcohol Abuse, 15*, 13-29.

Whelan, M. & Prince M. (1982). Toward indirect cognitive confrontation with alcohol abusers. *The International Journal of Addictions, 17*, 879-886.

White, W. C. of Boskind-White, M. (1981). An experiential-behaviorial approach to the treatment of bulimiarexia. *Psychotherapy-Theory Research and Practice, 18*, 501-507.

Wilcox, N. S., Prochaska, J. O., Velicer, W. F. & DiClemente, C. C. (1985). Brief report subject characteristics as predictors of self-change in smoking. *Addictive Behaviors, 10*, 407-412.

Williamson, D. A., Kelley, M. L., Davis, C. J., Ruggiero, L. & Blouin, D. C. (1985). Psychopathology of Eating disorders: A controlled comparison of bulimic, obese and normal subjects. *Journal of Consulting and Clinical Psychology, 53*, 161-166.

Wilms, K. E. (1986). Therapy motivation in Anorexia Nervosa: theory and first empirical results. *Psychotherapy and Psychosomatics, 46*, 161-170.

Wilson, G. T. (1987). Assessing treatment outcome in bulimia nervosa: A methodological note. *International Journal of Eating Disorders, 6*, 339-348.

Wolchik, S. A., Weiss, L. & Katzman, H. A. (1986). An empirically validated, short-term psychoeducational group treatment program for bulimia. *International Journal of Eating Disorders, 5*, 21-34.

Yalom, I. D. (1975). The theory of practice of group psychotherapy (2nd ed.). New York: Basic Books. In: P. Lewis (1987). Therapeutic change in groups. An interactional perspective. *Small Group Behavior, 18*, 548-556.

APPENDIX A

Description of the Interview Process

The Participant:

1) Reads "Purpose and Procedures of the Study".

2) Reads and signs "Consent Form".

3) Fills out the "Questionnaire".

The researcher shares her own experience with bulimia nervosa selectively, during the interview.

The tape machine is turned on.

General questions are then asked regarding factual information such as,

i) How long were you bulimic?

ii) How long have you been recovered?

iii) What was happening in you life at the time that your bulimia began?

When seen as appropriate during the interview, the researcher ensures that the participant is comfortable. The question of the study is addressed, "what experiences of recovery from bulimia nervosa are seen as most significant by the participants?" The interview questions from the "interview guideline" (see Appendix E), are used as needed.

APPENDIX B

Purpose and Procedures

The purpose of the study is to discover a common theme of the experience of recovering from bulimia nervosa by interviewing recovered bulimics and recording their views.

As a participant in this study, you will be interviewed at least once, for an hour or more. You may be interviewed a second time, only to compare differences found from another interview. Following the interview, you may be asked to read the researcher's interpretation of the data and give your opinion of how these interpretations fit the information obtained from the interview. You may be asked to read a summary report before the final draft, again, giving your feedback of the theory.

Finally, the researcher may stop the interview at anytime, deciding for example, that no new information pertinent to the study is emerging.

You are free to withdraw at anytime. Ask any questions or make any comments that you wish. There are no right or wrong answers. You are encouraged to answer all questions freely. If, at anytime, you feel a need to talk to a counsellor, the interviewer will recommend a counsellor, other than herself.

The reporting of this study will be in the format of a Ph.D. thesis in Educational Psychology from the University of Alberta.

APPENDIX C

Recovered Bulimics - A Theory of Recovery
Consent for Bulimia Nervosa
Consent to Participate

I have read the preceding page, and I understand the purpose and procedures of the above named study.

I understand that I am under no obligation to participate; I may withdraw at any time, or not answer any question.

I understand that the information which I provide will be kept confidential and my identity will not be revealed. The audiotapes will be stored under lock and key in the investigator's private office during the study, and erased upon completion of the study.

I understand that the results of the study may be published, but I will not be identified by name or in any way, and my name will not be associated with this study.

I recognize that I may experience some emotional discomfort as a result of the interviews and am aware that, should I feel the need to talk to a counsellor, the interviewer will recommend counselling services. The researcher will not be the counsellor.

I understand what is required of me, and I freely agree to participate in this study.

Participant Signature: _____ Date: _____

Investigator: _____ Date: _____

APPENDIX D

Questionnaire of Demographic Data

Name: Date:

Age:

Sex:

Occupation:

Marital Status:

Age of Onset of Bulimia:

Income Level:

Level of Education:

Ethnic Origin:

APPENDIX E

Interview Guideline

This is a guideline to be followed and adapted to the needs of the interviewer.

1) What experiences led you to recovery?

   i) Was there a particular therapy that you took?

   ii) Was there a therapist who was particularly involved in your recovery?

   iii) Was there an important person or persons in your life who influenced your recovery?

   iv) Was there something happening in your life that influenced your recovery?

2) When you came to the "Y in the road", where you could either continue in bulimic behaviour or where you could do something different, what was it that enabled you to take the positive turn?

   i) How frequently did you come to the "Y in the road" or choice point?

   ii) If once, how would you describe your experience?

   iii) If more than once, were there any differences in your experience?

   iv) Were there any similarities in your experience?

   v) Do you ever get those urges to be bulimic again? If yes, what is your experience?

3) What contributed the most; what made the difference in your recovery?

4) What have you learned in recovering from bulimia?

Questions for Validity

These are questions for validity and they are to check to see how you feel about the interviewer and to see what you understand about it.

1) What do you feel was the purpose of the interview?

2) How did you experience me?

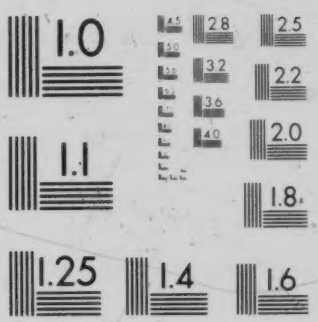
The participant is then reminded, as described in the procedures of the study, that she may be requested to read drafts

of the analysis in order to give feedback, be contacted for further information gathering or be questioned in order to examine differences found in other interviews.

The participant is then thanked for her time and willingness for participating in the study.

APPENDIX F

3 of/de 3



MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS
STANDARD REFERENCE MATERIAL 1010a
(ANSI and ISO TEST CHART No. 2)

Descriptions of Participants

All the seven participants were Caucasian and female. They met the DSM-III R (1986) criteria for their past bulimia nervosa. None abused drugs or alcohol. The participants did not experience anorexia nervosa and all but one have been recovered for one year or more. Three participants experienced formal treatment and informal treatment factors. Two participants experienced in informal treatment factors and one appointment with their medical doctor. Two participants experienced only informal treatment factors. All of the participants have stopped bingeing completely. They all said they may on occasion eat too much at dinner but just as a normal person might do. The following summaries, have been partly taken almost verbatim from the transcripts of the interviews. Generally the researcher uses the participants' words without quotation marks.

Participant One

Participant one is aged 34. She is divorced and living alone. She has three children aged 10, 7 and 5. They live with their father. She is a waitress and a salesperson, and earns $15,000 per year. She has grade nine and is presently doing equivalencies. Her bulimia began when she was 24 years old. At that time the participant was having marital difficulties. She was on the verge of leaving her husband, but did not want her marriage to break up. When she and her husband fought she would eat. She described herself as loving to cook and bake. As she did not want to gain weight she would throw up. Eventually her marriage ended and she received custody of their three children.

Participant one realized what she was doing and found she could not stop by herself. She went to her general practitioner for help and was given diet pills. She stopped taking them as they made her "fly". Her bulimia continued. The bingeing was draining her finances. She felt she was robbing her children of times of enjoyment, doing activities together like swimming. In addition the informant was tired of hanging over the toilet. She said she needed to stop and did not want to do it anymore.

One day three people arrived at her door and shared the gospel with her. This led to her reading the Bible and praying for God to help her. She felt He did. She was not sure how, but she found that one day she could go for an hour without eating and then went on to an hour and a half and suddenly for half a day. She went on to the next day and it kept going.

After the first week, the participant started bingeing. She felt this was because she was taking the credit for her recovery. The Bible reads that He shared His glory with no-one. She had been trying to take the credit for her recovery. After this realization the participant recovered from Bulimia nervosa. This person was bulimic for five years and has been recovered for five years.

Participant Two

Participant two is aged 31. She has been married for two and half years. She works as a letter carrier and earns $35,000 per year. Her level of education is grade 12. The participant's bulimia began when she was 23 years old. It happened by a fluke for her. She was at a Christmas party and had too much to eat and drink. Once at home she vomited. She described herself as being

deathly sick and then feeling very light afterwards. She thought it was an easy way to lose weight.

The bulimia progressed from there and was influenced by her boyfriend. He was critical if she gained three pounds. He worked out of town and when he was due back the participant's bulimia worsened. She said she felt it was due to someone else, her boyfriend. The participant told a girlfriend about her bulimia. After a month of no improvement, her friend drove her to a clinic for help. She received six months of individual counselling by a female psychologist. Her counselling took place in the first six months of her two year recovery process. Counselling helped get her going. She began to understand how she was numbing feelings with food. She also understood her negative relationship with her boyfriend much better. For her last year of recovery she binged and purged once a month. She left her boyfriend during counselling. Her motive for recovering was that she did not want to die. She had many health problems for example, getting meningitis twice. She felt she had to get better. She married her husband during her last six months of her recovery period. The participant did not tell her husband about her bulimia as she felt she was recovered. At present she realized that she was not recovered at that time.

The participant describes her friends as being very supportive. They encouraged her to get out of the house and go out with them. Several phoned regularly to see how she was doing with her bulimia. The participant was bulimic for a total five years and her recovery process was about two years. She has been recovered for two years.

Participant Three

Participant three is 29 years old. She is divorced and has a boyfriend. She works as an administrative assistant during the day and a receptionist at night. She earns approximately $36,000 to $37,000 per year. She has a high school education. The participant's bulimia began when she was 22 years of age. At that time she had stopped smoking cigarettes. She had also stopped drinking alcohol because she could not drink without smoking too. She started to gain weight. The participant then went on a diet for the first time. She had never experienced a weight problem before. She started thinking about food a lot and began exercising. She read about throwing up in a Cosmopolitan magazine and thought that it sounded like an easy way to deal with overeating at a meal. It began like this and from there, it gradually got worse and worse. Before long, the participant was throwing up every day.

The informant was married at the time. She felt that her whole life was a lie for example, her hidden bulimia and her failing marriage. The participant hated the lying. She was tired of hiding. She hated the bulimia and did not want it anymore. She told her husband about it. He thought it stupid. She waited four months to see a psychiatrist. She went weekly for individual and group sessions. She continues having bi-monthly sessions to keep working on herself. She said it helped her a great deal to be with other bulimics in a group. She felt much less alone. She also took an assertiveness training class. This participant took anti-depressants for one year and three months before leaving her husband and stopping the bulimic behavior altogether. She said that finally one day she woke up and decided that either the

cigarettes or the bulimia had to go. She chose the bulimia. She experienced a mild relapse where she purged twice in one week. She had been feeling really down she said. She had separated from her boyfriend and was in the middle of her divorce. It scared her, how easily it was to fall back into old patterns. She thought the relapse was positive because it "keeps her on her toes". The participant was bulimic for a total of six years. Her recovery process took about three years. She had been recovered for 11 months when the interview took place in February, 1990.

Participant Four

Participant four is aged 27. She has been married for five years. She has two children aged three years and two weeks. She is a dental assistant and earns $30,000 per year. She has a college education. Her bulimia began when she was 24 years old. At that time she was coming to terms with growing up in an alcoholic family of origin. She said she really didn't like herself and used her bulimia as a self-punishment. Her marriage was falling apart. She was also experiencing difficulties at work with a few girls. A close friend at work observed the participant eating lunch and then disappearing to the bathroom. Her girlfriend suspected as did her mother. She felt she was getting caught as she was being questioned about her behavior. Also, she kept it a secret from her husband. At the same time she had watched a TV movie about bulimia and had felt very frightened. She was also coming to terms with the abuse she experienced in her family of origin. The abuse had been stuffed down inside of her for a long time, she said. She had a nervous breakdown and wound

up calling her mother at 7:30 in the morning from work. Her mother asked her to come to an Alanon meeting.

The participant grabbed hold of the Alanon program and looked at herself and faced a lot of her past and her fears. She also saw her medical doctor for one appointment. He told her that since she was doing well through Alanon, she may as well continue with her program. She did not see him again for her bulimia. Her bulimia slowed down. When she got the urge to binge and purge, she used an Alanon strategy of calling a friend. Her marriage improved. Her husband felt badly that he had not known. He had thought his wife might be pregnant when she threw up. She felt she had to stop or else she would end up killing herself. She also stopped for her husband and her child. Her child would come into the bathroom and comfort her. She felt she had to get better. Eventually the participant stopped cold turkey. She had been bulimic for a total of two years and her recovery process took about one year. She has been recovered for two years.

Participant Five

Participant five is aged 27. She has been married for three years. At present she is seven months pregnant. She is a secretary and earns $20,000 per year. She had a grade 12 education. Her bulimia began when she was 16 years old. At that time her parents were going through a divorce. The family had just moved to a new city and the participant was starting a new school. She said that the feelings she had about herself were not so good. She said her whole life was just thrown out of wack. She felt overweight and began to purge after overeating. The

bulimia continued until she moved out on her own. It started to subside as she was doing much better living on her own.

The participant felt at this point that she experienced a relapse when she lived with a man who was verbally abusive. Her mother came to visit and caught her throwing up. Mother said just don't do it. Things started to get back on track for the participant as she got herself an apartment, got a job, and started meeting new people. She felt no one in particular influenced her recovery but instead it was her life getting back on track. Her motive for getting better was that she did not feel comfortable with her bulimia. She felt bad and ashamed. As her life improved she felt she should not be bulimic. She said it was no one thing that made her stop. Being more comfortable with who she was and what she was helped a great deal. It was a gradual process that worked itself out. When she had an urge to binge and purge she sat and thought about how she would feel afterwards - " horrible". Eventually it disappeared altogether.

When the participant first got married she experienced a mild relapse. She had a few episodes because of jealousy. She said her husband's ex-wife was very thin and the participant felt jealous. Her husband was very supportive. The participant had only talked with her husband, nobody else. She had very few episodes while being married to him.

Now the participant does not want the bingeing and purging to happen again. It is not something that she wants to go through again. Even though her bulimia got better when she got herself a job, an apartment and met new friends, she said she chose to get better. However she also said that she never made the decision that it would never happen again. Instead she is aware that the

bulimia is there but not active. The participant was bulimic off and on for nine years. The length of the recovery process is vague as she did not choose a specific time to begin recovery. She has been recovered for two years.

Participant Six

Participant six is aged 29. She has been married for five years. She has one child, two weeks old. She is a dietician and earns $38,000 a year. She has a Bachelor of Science in Home Economics. Her bulimia began when she was 20 years old. At that time she was going on a date with a boy. She had dated him a couple of times. She had eaten too many of her mother's homemade squares. She and her date had planned to go out for dinner and she panicked. She made herself throw up. As first it was not very frequent but it just got more and more out of hand for her. She had a lot of pressures at school and that made her bulimia worse.

The participant realized that her bulimic behavior was not normal, that it was wrong. She did not want to tell anybody because she wanted to deal with it herself. Her motive for getting better was that the bulimia was making her very unhappy. Also, it was making it difficult for her to cope with other things in her life. She just wanted to change, to stop. Her parents knew that something was wrong but denied it too. The participant reached a point where she was making changes in her life such as switching faculties and careers. She wanted to get her bulimia under control so she sought help.

The participant saw a psychologist for six months. She then ran out of money. It did help to talk to this woman as she

confided in her freely. She felt comfortable with this because the participant did not know her before. In addition, no one the participant knew, was aware that she was going to this woman for counselling. The participant was living at home at the time, and her parents knew she was getting help. The participant continued to be bulimic for 3 or 4 years but the severity was reduced. She had periods where she was doing other things and would forget about even wanting to binge and purge. The periods became longer and longer during which she was not bulimic.

The participant's husband knew she was bulimic before they were married. He had a very low tolerance for the behavior and thought it stupid. He said to not do it anymore. The participant had several relapses and her husband was very intolerant and told her not to do it. She did not tell him after that, when she binged and purged. She dealt with it on her own. She learned from relapsing to try to give herself positive reinforcement for example, that at least she was doing it less frequently.

Things just started coming together for the participant and her bulimia faded. She told herself that she was going to stop this and put it behind her. She has been recovered for one and a half years. Her bulimia lasted eight years and her recovery process during that time took about four years.

Participant Seven

Participant seven is 33 years old. She has been married just over two years. She has a two year old son and is six months pregnant. She is at present a correctional officer and earns $31,000 per year . She is a teacher and has a Bachelor of Education. Her bulimia began when she was 18 years old. At that

time she had just left home. She had a job and was sharing an apartment. She did not like her job or where she was living. She had a relationship with a boyfriend that was on the rocks. Once she got started, she didn't realize that she was bulimic. The bulimia continued off and on for thirteen years.

The participant realized she was bulimic from reading about it in newspaper articles. She became aware that it affected one's health. This scared her a bit. Bulimia also took up much of her time. She would leave a party or restaurant just so she could go home to binge and purge. It dominated everything she did and she felt angry about this. Her bulimia was phasic, and it never stopped, for example, there was never a week without bingeing. Her motives were not strong enough to enable her to stop. She then became pregnant and decided to stop for the sake of the baby. She was sick and nauseated from the pregnancy and had very little difficulty stopping the bulimic behavior. She told herself it would be just until the baby was born. Once the baby was born, she had lost her desire and habit of being bulimic. She decided it would be better to continue on, eating normally. She wondered if the bulimia could return and decided that if it did, she would get counselling. She did not want to do it anymore. And it was over.

The only person that participant ever told about her bulimia was her husband. She said it was not crucial to her recovery, but it was a relief to talk to somebody. He was encouraging and not condemning in any way. He told her that he wanted her to stop.

The participant has been recovered for 1.25 years. She was bulimic for 13 years and her recovery process took about 9 months or .75 years.

APPENDIX G

EXTERNAL AUDIT

The auditor had a Ph.D. in mathematics. He had considerable experience in the field of psychology and personal development and change. He was selected because of his scientific background and personal experience with opening and growing. He was chosen for his analytic abilities and history of experience in psychology and research.

The researcher met with the auditor on two occasions. First was midway through the study. The meeting involved briefing the auditor on the state of the research. The second meeting occurred at the end of April. Materials were given to the auditor for the preparation of the report. The external audit report was delivered to the researcher at the end of May, 1990 by the auditor. The auditor's appraisal follows.

1. DEPENDABILITY AUDIT:

A. Materials presented to the auditor were: 1) Chapters from Ms. O'Byrne's thesis dealing with Grounded Theory, descriptions of subjects participating in the study of recovery from bulimia nervosa, her theoretical overview (identifying a Basic Psychosocial Process termed "Opening the Self"), and a chapter describing this process in more detail with supporting quotations taken from subject interviews; 2) An audit trail consisting of eighteen pages of notes indicating the process of identifying variables, establishing core concepts, and generating hypotheses; 3) A set of journal notes consisting of thirty four pages, covering the time from Jan. 27, 1990 to April 25, 1990; 4) The full set of subject interview transcripts as annotated for critical analysis.

B. Procedures used by Ms. O'Byrne in her study appear to be well within the normal bounds established for this type of theorizing. Her initial categorization (following direct analysis of the interviews) identifies 45 variables. In subsequent levels of synthesis these are grouped under common themes (categories) and used to generate the process description contained in Chapter V of her thesis. Her audit trail shows evidence of care taken to achieve saturation on variables, via follow-up subject interviews, and exhibits the back and forth interplay which occurs in the development of substantive theory from data.

2. Confirmability Audit:

A. The basic theoretical overview given in Chapter IV of Ms. O'Byrnes thesis consists of four stages in the recovery process. This process is described in more detail in Chapter V. In this chapter each of the posited stages is well supported by direct quotation from subject interviews, and hypotheses are not generated which go beyond information which is contained in these quotations. Quotations from different subjects are used to elucidate similarities and differences in the course of recovery, and those differences which do arise are indicated and shown to still be consistent with the general hypothetical process.

B. On the basis of my review of Ms. O'Byrnes work I feel confident that each of her hypotheses and interpretations are supported by, and consistent with the collected data (i.e., the texts of the subject interviews). Important segments of the data were not excluded. I would suggest, however, that she highlight some comments on the possible relevance of couple relationships as a factor in recovery. In particular, I noted that two of the

subjects specifically associate the beginning of recovery with resolution of unsatisfactory relationships.

C. The chart titled "Outline of the Process of Recovery from Bulimia Nervosa" provides a concise review of the final hypothesized theory. Again, each of the substantive codes (and their defining properties) can be found to be supported by information contained in subject quotations in Chapter V. The inductive categorization of these codes into four stages is justifiable on the basis of the temporal order in which these codes emerge in the subjects' descriptions of their experiences of recovery. The theoretical codes are similarly justified as being the significant factors which were involved.

Appendix H

Secondary Literature Review as Related to the Theory of Recovery From Bulimia Nervosa

Opening is addressed first, in the context of development. Next, self is described in relation to responsibility for change and awareness preceding resolve to change. Then, personal resolve followed by stages, temporal factor and cyclical pattern are addressed. Lastly, the substantive codes, which form the 4 stage theory of recovery, are discussed. It is noteworthy that only one article in this review used a qualitative approach. The article addressed recovery from substance abuse and delinquency (Stuck & Glassner, 1985).

Opening

In this study of the recovery from bulimia, opening emerged as a theoretical code in the process of recovery from bulimia. Change in the self is implied by this concept, where opening moves the person towards health and closing sets the stage for the generation of unhealthy behaviors.

Self in the context of early development, can be seen as conditioning resulting in aspects of the self closing. This conditioning may result, for some persons, in a lack of self-regulation and in forms of disordered eating such as bulimia nervosa (Orbach, 1984).

In the process of the development of the self the experiences of the individual can lead to a healthy or unhealthy psychological positioning. In describing healthy people Rogers (1987) has written that some of the key factors in healthy people are an openness to the self, trusting the self, openness to experience, openness to change and of being inner-directed. On

the other hand, unhealthy behavior or dis-ease is characterized by being out of touch with the self, resistance to change, lack of personal control, and denial of personal experience (Van De Riet et al., 1980).

In the process of recovery from bulimia it seemed that change was dependent upon the individuals opening themselves.

Self

It appears that change begins with the self. In the literature, reference is made to the self being responsible for change. For example, Whelan and Prince (1982) wrote that self-responsibility is essential to recovery from alcohol. Yalom viewed the crucial mechanism for change as being responsibility for the way in which the self is experienced (Lewis, 1987). Clarkson (1989) wrote that people can take responsibility and be active in their own healing processes. Each person is responsible for the experience of her own life [self].

It is difficult for the self to change because it took a long time for the dysfunctional patterns to develop. It is commonly believed that obesity, cigarette smoking, and heavy drinking are highly resistant to change (Perri, 1985). A key point in changing is being aware enough of the self to want to change. Awareness of the self is even therapeutic on its own as described by Perls (1969). Frequently, becoming aware of what is happening in their self is followed by a desire for change. Although awareness and resolve are closely related the awareness of the self as originator of change necessarily precedes resolve to change.

The self and personal resolve to change are closely interrelated because it is the self that is resolved to change. For example, the 20 year-old delinquent who stopped taking drugs and committing crimes reported that ". . . the only way [people] are going to change . . . [is] because they want to change. Its got to come from in here, your heart . . ." (Stuck & Glasner, 1985). This statement reflects the notion of the self being involved in the resolve to change. Self implies awareness of self in the context of change where resolve is the motivation to create desired changes.

Personal Resolve

Personal resolve emerged as an important factor in the recovery process from bulimia nervosa. Only one article in the secondary literature was found which used the term resolve, in relation to recovery (Jackson, 1986). The article discussed the recovery of a 9-year-old girl from anorexia nervosa through family therapy. After 6 monthly sessions, the therapist told the girl that if she really wanted to get over it she could and that she would if she really wanted to. It was decided by the family and the therapist to stop therapy at this point. Later, the author questioned why the girl got better. It was concluded that the girl did not want therapy anymore, that enough change had taken place. Her dislike of therapy, they speculated, contributed to her "resolve" to get better (Jackson, 1986, p. 73).

Literature on motivation seems to be the closest in describing personal resolve. Brownell et al. (1986) wrote that very little work has been done on motivation. Maslow is best known for his motivation theory and research on self-actualized

persons (Brammer, 1984). Maslow's basic ideas suggest that there is a hierarchy of human needs with food and other physical survival needs at the lowest level. They are subsumed by security, social needs, and finally the need for growth or self-actualization (Maslow, 1962). Perhaps the resolve to open the self and overcome bulimia or addictions and Maslow's need for growth, are related. It seems that motivation or personal resolve is related to an inner need for growth.

In a study by Perri (1985), successful and unsuccessful quitters were examined across the problem areas of obesity and smoking. Successful subjects rated themselves as more motivated and committed to personal change than unsuccessful subjects. Perri then asked, "What caused the successful individuals to become more motivated in dealing with their problems?" (1985, p. 299) He suggested that the greater the perceived discrepancy between what one is doing and what one ought to be doing, the greater one's motivation and commitment to change. It is suggested that along with an intrinsic need to open the self, there are personal motives which influence the level of motivation or personal resolve. Motive, a substantive code in the theory, will be discussed below as related to internal and external motives.

Stages

The theory for recovery from bulimia emerged from this study with four clear stages: contemplation, action, recovered and maintenance. Several stage theories were found in the literature review. A model of change proposed by Daley (1989) viewed recovery from alcohol and substance abuse as a developmental

process with six predictable recovery periods. They are (i) pretreatment, (ii) stabilization, (iii) early recovery, (iv) middle recovery, (v) late recovery and (vi) maintenance. Horn (1976) enumerated four stages of change in smoking cessation (i) contemplating change, (ii) deciding to change, (iii) short-term change, and (iv) long-term change. Brownell et al., (1986) suggested three basic stages of behavioral change across the addictive disorders of alcoholism, smoking and obesity. The stages are (i) motivation, (ii) commitment, initial change and (iii) maintenance.

Prochaska and DiClemente have done the most thorough work in the area of stages of change, by evaluating stage models of smoking cessation and therapy in general (Brownell et al., 1986). From their study five stages were suggested: (i) precontemplation, (ii) contemplation, (iii) action, (iv) maintenance and (v) relapse. This model is called the transtheoretical model of change. The stages are characterized as follows. Precontemplation is described by no thought of changing. Contemplation is represented by a serious consideration of changing. Action is the stage when active attempts to change occur. Maintenance is characterized by coping successfully and attempting to maintain the new behaviors. Relapse is represented by a return to previous behavior for varying lengths of time and degrees of abuse. This model of change focuses more specifically on ten processes of change. These processes occur in varying degrees in the stages. The processes are consciousness-raising, self-liberation, social liberation, counterconditioning, stimulus control, self-reevaluation, environmental reevaluation, contingency management, dramatic relief and helping relationships

(Prochaska & DiClemente, 1986). These processes refer to what people do in order to change behavior, such as smoking, but do not address other experiences of people who have recovered from an addictive disorder. In the current study on recovery from bulimia, the contemplation stage, action stage, and maintenance stage are similar to those of the transtheoretical model. However, the recovery stage from bulimia contains aspects of the experience of recovery not addressed by the transtheoretical model, for example, how the behavior stopped suddenly or gradually, the individual choosing to stop the behavior, knowing it was over and yet never over and how individuals function better.

Temporal Factor

Stages in both the transtheoretical model and the theory of recovery from bulimia nervosa share similar characteristics of a temporal factor and a cyclical pattern. In the opening of the self there was the notion of time, where change occurred over time. This notion has not been reported in the literature review on change processes. Another aspect of the temporal factor is the timing involved, where the importance lies not only in doing something about it, but also in when to do it. This factor was discussed in relation to smoking (DiClemente & Prochaska, 1985). Timing is individual.

Cyclical Pattern

An important conceptual advance in the process of change has been the emphasis on a circular rather than a linear model of change. Linear models have stages which occur in a sequence with

relapse occurring at the last stage (DiClemente & Prochaska, 1982). The circular concept is more in keeping with the theory of recovery from bulimia nervosa. A circular model of change shows relapse leading back to an earlier stage from which a person may make another attempt to change (DiClemente & Prochaska, 1982). A cyclical process refers to how individuals enter into the stages of recovery and exist, perhaps numerous times (DiClemente & Prochaska, 1985). Relapse may be frequent (DiClemente & Prochaska, 1985). The circular and cyclical concepts seem to be almost synonymous.

Substantive Codes and Properties

Mead advanced the symbolic interactionist school of thought where the focus of observation is on interaction. To be understood, human behavior must be examined in interaction with the setting, the implications in the setting, and the larger social forces such as ideologies and events that affect behavior (Chenitz & Swanson, 1986). One way to view the process of opening the self is from an interactional perspective. A r ness to change, open and recover, may be a developmental factor, an experiential one, or an inner drive, which interacts with both subjective and structural elements to cause change (Stuck & Glassner, 1985). In the following discussion of substantive codes and properties in accordance with the stages, it appears that the process of recovery involves an interaction and combination of factors.

1) Contemplation Stage

Realizing the behavior. The first substantive code of the contemplation stage was realizing the behavior. Realizing the behavior had three properties: media, getting caught and intrinsic.

1) Media - Some people become aware through magazine articles and radio programs discussing personal problems (Clarkson, 1989). Thus, articles and programs help individuals realize aspects of themselves. The effects of these articles and programs may be examined indirectly from the following study which involved helping people appraise their personal habits.

The goal of the "Health Hazard Appraisal" (HHA) was to motivate people to change personal habits and conditions that left unchanged would likely lead to premature death (Doerr & Hutchins, 1981). The HHA is an instrument which helps to identify personal habits that are detrimental to health. It was found that HHA together with a supportive educational process, increased knowledge level, shifted attitudes toward personal health and was effective in inducing the college students to change some health behaviors. HHA was most effective in influencing alcohol consumption, exercise, breast self-examination and weight reduction in low risk groups. Behaviors not affected were smoking, blood pressure and obesity. These behaviors probably require longer periods of counselling and more time to detect change. Doerr and Hutchins (1981) suggest that a change in knowledge might indicate a positive trend toward change.

2) Getting caught - Another way in which people realize they have a problem is by getting caught. No pertinent literature was found related to this property except for the delinquent

referred to earlier. He was forced into treatment after being caught committing a robbery (Stuck & Glassner, 1985). It is proposed that getting caught increases consciousness of oneself. One becomes more aware of one's behavior as another is seen witnessing the behavior. Also, consciousness-raising is the most widely used change process across diverse therapy systems (Prochaska & DiClemente, 1986).

3) Intrinsic - People realized they had a problem by an intrinsic sense of knowing or because awareness was focused on the problem through some external factor. Yalom stated that self-awareness was a basic mechanism of change in group therapy (Lewis, 1987). Clarkson (1989) wrote that people commonly become aware of their desire to seek help when there is some disturbance to the homeostasis of their lives. The awareness of the state of the self acts as a trigger to seek help. Clarkson was making reference to a woman who was experiencing feelings of loss when her children left home.

Generating Motivation. The next substantive code in the contemplation stage involves motives generating motivation to overcome the bulimia. It is proposed that internal and external motives are also related to a need to continue opening the self.

A frequently mentioned motive in the literature is the desire for health. Persons who experience a direct threat to their health are likely to develop new behaviors (Wilcox, Prochaska, Velicer & DiClemente, 1985 and Perri, 1985). Fear for one's life, threat of divorce and the possibility of being fired from a job, are motives called nonlegal coercion. These factors as motivators for treatment are so common that they are seldom

studied as factors in outcome for substance abuse, such as tobacco, alcohol and opiates (Westermeyer, 1987).

Daley (1989) explored recovery from alcohol and substance abuse and wrote that a motive may be external, such as the attempt to save a job or marriage. At first the person does not need an internal motive but eventually, the motivation must become internalized. The ideas developed by Daley (1989), Wilcox et al., (1985), Perri (1985) and Westermeyer (1989), may be applied to this study since the women reported similar experiences as generating motivation.

2) Action Stage

Taking action. The first substantive code of the action stage is taking action. It is characterized by three properties: telling, formal treatment and informal factors.

1) Telling - The term telling was not used in the literature. However, a similar concept was the idea of opening to others. France, McDowell and Knowles (1984) wrote that loneliness is accompanied by the feelings that persons have nothing useful to offer or receive from others. Opening up to others helped individuals in coping with loneliness. A change occurred in that persons felt less lonely after opening to others.

2) Formal treatment - Another step of taking action is by entering formal treatment. "Why some individuals go to therapy programs for smoking cessation rather than quitting on their own continues to be an intriguing question" (DiClemente & Prochaska, 1982). Articles written on formal treatment address factors such as motivation and treatment strategies. The articles do not address the experience of the person in formal treatment. In the

beginning of treating anorexia, Wilms (1986) wrote that the level of motivation is of particular importance, for example, there needs to be a desire for change and not only symptom removal. Treatment for anorexia and over-eating need to address three factors: motivation, insight into one's condition and using information from models of addiction. Bachmann and Röhr (1983) believed these factors are compulsory and need to be addressed in sequence.

Treatment may occur individually or in groups. Two of the participants experienced group treatment, one formally with a psychiatrist and another informally through an Alanon program. The participants reported similar experiences to the following. Lawrie (1982) wrote that people in a group will experience behavioral commitment through peer pressure and reported successes involved in interpersonal relations and personal experiences. People will develop new behaviors. The author's article addresses general attitudes and motivations being changed and developed.

A visit to one's medical doctor has been coded as an aspect of formal treatment in the treatment of bulimia. Two women reported a visit, for one it was a positive experience, for the other negative. The family physician can be astute enough to ask the right questions and wise enough to know when action is indicated (Sherin, 1983).

3) Informal factors - It is noteworthy that at a five month followup self-quitters were able to maintain cessation of smoking as well as the subjects who attended treatment programs (DiClemente & Prochaska, 1982). There is evidence that substantial numbers of people are able to deal with smoking, obesity and heavy drinking on their own (Perri, 1985). In the

process of change, people are capable of self-correction (Watzlawick, Weakland, and Fisch, 1982). Perri (1985) examined self-change strategies for the control of smoking, obesity, and problem drinking. It was reported that self-quitters used a greater array of factors than did unsuccessful problem drinkers. They had more support from family and friends and help from others such as Alcoholics Anonymous. These findings may be applied to this study since most of the women reported similar informal factors.

Social support was found to be crucial in the behavior change process; however, variations in social relationships make it unlikely that any single approach will work consistently. For example, enlisting the aid of a spouse may have positive effects in some marriages and negative effects in others in maintaining recovery from smoking, alcohol abuse and obesity (Brownell et al., 1986). Women reported in the present study that their "partners", boyfriends or husbands, had either a positive or negative effect.

As was described earlier, people who abstained from alcohol, used a greater array of factors, such as strategies, in order to cope. Examples of strategies are stimulus control, such as removing alcohol from the home, and the development of alternative behaviors to take the place of drinking (Perri, 1985).

Prochaska and DiClemente (1985) outlined a set of change processes common to problem areas such as psychic distress, smoking and weight control. These self-change processes refer to what the persons do to recover. The authors found that subjects seem to use a similar pattern of processes in taking action with these problem areas. The six processes most commonly used are consciousness raising, self-liberation, reinforcement management,

helping relationship, dramatic relief and stimulus control. Examples of these processes are given with substitutions of smoking, over-eating and distress. Consciousness raising was depicted as "I look for information related to smoking"; self-liberation involved "telling myself I can choose to over-eat or not"; reinforcement management was written as "I am rewarded by others if I don't become distressed"; helping relationship involved being "open with at least one special person about my experience with smoking"; dramatic relief was written as "dramatic portrayals about over-eating effect me emotionally" and finally stimulus control "I put things around my home that remind me not to become distressed" (Prochaska & DiClemente, 1985). These informal factors as described by Prochaska & DiClemente (1985) are applicable in this study since similar processes were reported by women. For instance, women said that they chose to stop the bulimia, that family members were happier that they were no longer bulimic, that they felt relief in telling someone about their bulimia, that television shows about bulimia affected them and finally, that they did other things in order for them not to binge or purge.

In a study by Westermeyer (1989) nontreatment factors were examined and compared to treatment factors. It was found that success rates for alcohol abstinence were 44 percent in the no treatment group, 33 percent for Alcoholics Anonymous and 32 percent for clinical treatment. An informal treatment factor called community reinforcement approach was positively correlated to success in stopping alcohol abuse. This was similar to AA. Relocations such as moving to a new city or neighborhood were positively correlated with abstinence from opiate and alcohol

abuse. Marital status such as living with another, was positively correlated with abstinence from alcohol. Finally the church was rated as positively correlated with successful stopping of alcohol (Westermeyer, 1989). These findings may be applied to this study since the women reported similar factors as significant in their opening. For instance, one woman attended Alanon which is similar to AA and another reported moving to a new apartment as helpful. Some women reported marriage as helping them to recover and one woman reported her belief in God as significant in her recovery from bulimia.

Subsiding. The second substantive code of the action stage is subsiding. It has three properties, gradual, forgetting about it and taking care of itself. No relevant literature was found on this code or its properties.

3) Recovered Stage

Stopping. The recovered stage begins with the substantive code stopping. The bulimia stopped in two ways, either gradually or suddenly. The property gradual was not found in the secondary literature review on recovery from addictive disorders. Stopping suddenly was addressed in two articles on stopping smoking. The term used to describe the sudden stopping was "cold turkey" (Edwards, Simmons, Rosenthal, Hoon et al., 1988, p. 203 and Gunn, 1986, p. 49). In one study, 21 women quit smoking cold turkey and another 8 women stopped and received an antidepressant. Withdrawal symptoms were less severe for women who received the anti-depressant (Edwards et al., 1988). In another study self-report measures of withdrawal symptoms, after quitting cigarettes cold turkey, were examined. Almost all of subjects reported

discomfort. Sex differences were apparent. Women who reported intense withdrawal symptoms were less likely to remain stopped. For men, withdrawal distress was not related to outcome. It was suggested that the sex difference was due to cultural learning (Gunn, 1986).

Choosing health. Choosing is the second substantive code of the stage recovered. No relevant literature was found on this code.

Knowing. Knowing was not found explicitly in the literature review on processes of recovery. The notion of self-efficacy will be discussed here as it involves a type of knowing, that is, a person's belief that he/she can respond effectively to a situation by using available skills (Brownell et al., 1986). Bandura (1977) proposed the concept of self-efficacy as a model that attempts to account for behaviorial change as a result of strengthening expectations of personal efficacy. Self-efficacy is reported as playing a critical role in succeeding in the face of difficulties such as in alcohol abuse (Prochaska & DiClemente, 1986).

Self-efficacy can be viewed as two independent expectancies. These expectancies were addressed in relation to behaviors dangerous to health such as smoking. The first is an outcome expectancy, the belief that a given behavior will lead to a given outcome. The second expectancy is a self-efficacy expectancy where the person believes that he/she can perform the requisite behavior (Maddux & Rogers, 1983). The concept of self-efficacy is important. Studies have found that measures of self-efficacy were associated with positive outcome in overcoming obesity (Brownell et al., 1986). In smoking cessation, higher levels of self-efficacy contributed to active change and maintenance

(DiClemente & Prochaska, 1985). Evidence suggests maintainers have higher self-efficacy scores than recidivists in stopping smoking (DiClemente, 1981). Self-efficacy was found to increase from precontemplation to contemplation, to action and into maintenance in alcohol abuse (Prochaska & DiClemente, 1986). Only one woman in this study expressed a belief that she could recover from bulimia. Several of the women referred to believing that they would be all right, that they would get better. Thus the notion of self-efficacy was not reported explicitly as significant to the process of recovery from bulimia by most of the women. Rather a sense of self-efficacy was reported in terms of the women "knowing" that they would get better and that they would be all right.

Relapsing. The fourth substantive code of the stage recovered is relapsing. The transtheoretical model places relapse in a stage of its own. It follows maintenance (Wilcox et al., 1985). In the present study, relapsing was conceptualized as an aspect of the recovered stage. Relapsing was comprised of two properties, not always and learning.

Research demonstrated relapse as being a rule rather than the exception. In alcohol abstinence, 84 percent of persons in the sample moved back to contemplation (Prochaska & DiClemente, 1986). In a sample of 961 persons 195 relapsed to smoking behavior (Wilcox et al., 1985).

Stress, anxiety, depression, and other emotional states are related to relapse (Brownell et al., 1986). It may be seen as a failure, or relapse may have positive consequences of learning, if it prepares the person for later success (Brownell et al, 1986).

These characteristics were also reported by the women in this study, whether they relapsed or not.

According to Daley's (1989) model of recovery for alcohol and substance abuse, how the person views a relapse will determine whether a "full - blown" relapse will occur (p. 48). A relapse or lapse can represent an opportunity for growth.

A final point that Brownell et al., (1986) made was that family and friends may feel unhappy and sometimes angry when there is a relapse with smoking, alcohol and over-eating. Brownell et al., 's (1986) findings apply in this study as well, since generally women reported spouses feeling unhappy about a relapse.

Functioning better. The final substantive code of the recovered stage is functioning better. This code has two properties, inner-directed and generally happier. Inbody and Ellis (1985) found similar results with anorexic and bulimic patients. All persons expressed feelings of increased control of their lives, increased self-confidence, and improved self-image. All had made strides in becoming more assertive and in handling negative feelings. The other articles addressing smoking, alcohol, drugs and obesity, did not address personal gains made in abstinence.

4) Maintenance Stage

The maintenance stage was comprised of three substantive codes: eating, exercising and monitoring feelings. Eating was not addressed in the literature.

Maintenance was described by DiClemente and Prochaska (1982) as perhaps not being maintenance but instead continued change. In their study on smoking cessation, the maintainers reported that

self-statements about smoking, physical activity, and active control over smoking related events were especially important in maintaining abstinence. These strategies seem focused on the notion of "knowing" the smoking [bulimia] may return.

Exercising. Exercise may play a special role in addictive disorders. Physical activity has a natural role in the weight control field, but there is increasing evidence that its generalized effects may also benefit patients in the smoking and alcoholism areas (Brownell et al., 1986). Exercise may provide a general lifestyle activity that brings gratification. It may influence self-concept in a positive way. There may be physiological effects which influence appetite. Appetite usually reduces after exercising (Brownell et al., 1986). These findings were not directly reported by the participants in this study except for participant 1 who reported losing weight when she began exercising. Perhaps these findings could be applied to the study in that several women reported exercise as being important for maintenance. Women experienced benefits from exercising.

Monitoring feelings. The literature deals indirectly with the substantive code feelings/self in that authors address related aspects of the self such as personal growth and lifelong treatment.

Maintenance as described by Daley (1989) is a recognition of a need for a daily lifelong program of recovery from alcohol and substance abuse, with personal growth emerging during the last period of recovery. Brownell et al., (1986) wrote that a traditional approach to preventing relapse to smoking and alcohol abuse is to adopt a model of lifelong treatment. This model is inherent in Alcoholics Anonymous, where members are always

recovering and never recovered. This same philosophy applies to Overeaters Anonymous. These findings apply indirectly to this study. The participants did not report the notion of lifelong treatment of bulimia. They did report that they were still growing and that the bulimia could return if they returned to old habits. Thus the women were cognizant of continued development. There is only a difference in regard to the emphasis on time.

Three areas of intervention that may be appropriate for the maintenance phase are continued monitoring, social support and general lifestyle change (Brownell et al, 1986). These factors are discussed in relation to treatment. Continued monitoring refers to self-evaluation or contact with a professional. Persons profit from monitoring that extends beyond initial treatment. This notion of monitoring also seems to apply to persons who do not receive treatment for example in the case of participant 4. One participant continues to see her psychiatrist as a means of continued monitoring and growth.

General lifestyle change may also be helpful. The concept is that a source of gratification can be substituted for the absence of the dysfunctional behavior. Little research has been done on this notion (Brownell et al., 1986). The notion of general lifestyle change being beneficial can be applied to this study as all of the participants in the present study of recovery from bulimia reported a similar notion of lifestyle change in that they became active in areas of their life such as career and social interaction.

The ideas raised in the maintenance stage reflect continued change and health. Examples are general lifestyle change and continued monitoring of the self.

Summary

The purpose of this chapter was to discuss a secondary literature review in order to provide comparisons for the theoretical and substantive concepts and properties that emerged from the data. Generally speaking, comparisons could be made from results of the quantitative studies in the secondary literature review. It is noteworthy that comparisons between qualitative and quantitative research, demonstrate accessing similar data pertaining to psychological and social factors involved in experiencing. Also, these comparisons illustrate the differences, such as the properties of the bulimia stopping. The differences seem to occur when individuals are studied using qualitative methods (interviewing), and when individuals are examined using quantitative methods (given questionnaires). Interviews have the potential of allowing new ideas to emerge. A wider breadth of experience may be addressed. It seems that personal interaction during the interview, stimulates people to respond. The interview situation is a social context where the interviewer can be supportive. The context for using questionnaires is usually clinical and impersonal. Writing is a more constrained medium than is verbal. These factors influence the type of data that are collected. The context of the interview seems to allow greater opening and sharing and thus depth and detail to the information being sought.